INNOVATIVE
HEALTH CARE CONCEPTS
790 S. Holmes Ave. | Idaho Falls, ID 83401 | t. 208.529.8526 | f. 208.529.8597
Trusted Guidance, Quality Care

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Innovative Health Care Concepts, Inc. to use and/or disclose my protected health information as described below to and from

(name and contact information of recipient) ____

____

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

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I understand that:

1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Innovative Health Care Concepts, Inc. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Innovative Health Care Concepts, Inc. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:
☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Comprehensive Diagnostic Assessment
☐ Neuropsychological/Psychological Eval
☐ Treatment Plan
☐ Habilitative Intervention Assessment
☐ Implementation Plan
☐ SIB-R
☐ Medical Social Developmental Assess.
☐ Communication regarding treatment and progress
☐ IEP and Eligibility Report
☐ Therapy Plans and Evaluations
☐ Medical Evaluations (WCC, Annual Physical, etc)
☐ Special Medical Needs form
☐ Billing Records
☐ Other ____________________

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In addition, I authorize that this will include the following Super confidential health information relating to (initial if applicable):

____HIV/AIDS infection ____ Drug/Alcohol abuse ___Psychotherapy records ____Psychotherapy notes

Expiration: This authorization will expire 365 days from the date of signing or (insert date) ____________________.

Patient Name: ______________________________ **DOB:** ______________________________

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Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

____
Signature of Witness - Required only if the signature above has been signed by mark ("X").

____
Date