AUTHORIZATION TO DISCUSS

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: ____

The health information you may release subject to this authorization is as follows:

____

____

Do you authorize NorthWest Counseling & Associates to discuss your treatment with another party?

YES NO

Other: __________________________________ Relationship: ________________________________

Other: __________________________________ Relationship: ________________________________

Other: __________________________________Relationship: _________________________________

The reasons or purposes for this release of information are as follows:

____

____

This authorization shall be in force and effective until the following event and/or date:

____

____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the practice:

NorthWest Counseling & Associates'
Attn: Privacy Officer
18301 N. 79th Ave, STE F170
Glendale, AZ 85308

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____

Signature of Patient or Personal Representative **Date**

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority