Dr. Deena Abbe, Clinical and School Psychologist
Long Island Family Therapy
358 Veterans Memorial Hwy, Suite 12
Commack NY 11725
Tel 631-656-6055 **E-mail** dabbephd@gmail.com

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long island family therapy

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

1. I, hereby, authorize my health care provider, _____, and/or administrative and clinical staff, located at

_____
__

to disclosure my protected health information, as specified below, to:

_____
__

_____
__

2. By initialing below, I, hereby, authorize the disclosure for the following protected health information (PHI):

_____ Complete health care record

_____ The complete health care record for the following dates: _____ to _____

_____ The limited health care record as follows:

_____
__

3. _____ If initialed, I, hereby authorize my health care provider to speak with the individual/entity named in this authorization and to release information as specified above that my health care provider deems appropriate.

4. This protected health information is being used or disclosed for the following purposes:

_____

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5. This authorization shall be in force and effect until _____ after the date below at which time this authorization to disclosure protected health information shall expire.

6. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my healthcare practitioner.

I understand that a revocation is not effective to the extent that my healthcare practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

8. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of created protected health information for disclosure to a third party.

9. If this authorization is for any of the following information, it must be initialized below:
_____ Alcohol/drug treatment
_____ Mental health information
_____ HIV-related information

I have read and understand the provisions of this authorization.

_____ _____
Signature of Patient/Parent Date

_____
Print name signed