**HIPAA AUTHORIZATION FORM**

| | |
|---|---|
| X | N/A |
| **Patient's Full Name** | **Medical Record Number** |
| X | X |
| **Address** | **Patient's Date of Birth** |
| X | X |
| **City, State Zip Code** | **Patient's Telephone Number** |

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me, as well as receive disclosure of protected health information about me.:

   **Deirdre Eberhart, LCSW and/or Eberhart Therapy, LLC**

2. The following person (or class of persons) may receive disclosure of protected health information about me as well as disclose information about me::

   X
   **Name of Person or Organization** **Phone Number and Fax# (if applicable)**

   X
   **Address**

   X
   **City, State Zip Code**

3. The specific information that should be disclosed is (please give dates of service if possible):

X _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying **Deirdre Eberhart, LCSW** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for
7. This authorization expires upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

| | | |
|---|---|---|
| X_____ | X_____ | X_____ |
| **Signature of Individual*** (The person about whom the information relates) | **Date of Individual's Signature** | **Date of Birth** |

*OR, if applicable –*

| | | |
|---|---|---|
| _____ | _____ | _____ |