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**

   X
   Address

   X
   City, State Zip Code

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

X _____

YES, DISCLOSE THIS INFORMATION X_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

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 __**Disclosure of information to another entity**
7. This authorization expires on (enter date 1 year from today X_____), OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

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

OR, if applicable –

_____	_____	_____