Farmer Mental Health Support Program
Community Access

Authorization to Disclose Health Information

I, ________________________________, born on this date ______________
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, PLLC** to receive

Protected Health Information (PHI) about the above referenced individual from:
(Community Provider. You are allowing information to be released from the following person.)

Name:	Phone:
Address:	

No identifying information is shared with administrators of the Farmer Mental Health Support Program or related agencies. Information to be disclosed under this authorization is limited to information required for billing such as dates of service, service codes and confirmation of program eligibility.

Means of disclosure may be written, verbal or electronic.
Date range of information to be disclosed is date range of services supported by the Farmer Mental Health Support Program.
The purpose of the disclosure is coordination of services and payment.
This authorization will expire upon termination of services and/or meeting reimbursement limits after finalizing amounts owed.

- I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.
- I understand that confidentiality of such records is protected by State law.
- I understand that treatment is not conditioned upon signing an authorization form, however eligibility for financial support under this program requires signature of this limited authorization form.
- I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

____
Name of Client (please print)

____
Signature of Client

____
Date