Karen R. Stefano Ed.M., M.A., L.P.C.
25 Homewood Court
Charles Town, WV 25414
304.728.6757

HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Pursuant to federal regulations, we are required to obtain your authorization for the release of your protected health information in certain circumstances. This document has been designed to comply with those regulations.

I hereby authorize, Karen R. Stefano to disclose the following health information about me:

_____

For the following purposes:

To the following parties:

Request where to contact you:

- ❑ Home _____
- ❑ Work_____
- ❑ Cell phone _____
- ❑ Other contact numbers _____
  _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to **Karen R Stefano, 116 East 3rd Avenue, Ranson, WV, 25438**.

I understand that I am not required to sign this Authorization, and that my refusal to sign will not affect my eligibility for treatment, benefits, or coverage.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

This authorization will expire on [date]: _____

_____ _____ _____
Signature of patient or representative Date Patient Name

_____ _____
Personal representative's name Relationship to patient