AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION IN EMERGENCY CONSULTATION

1. Client's name: _____
   First Middle Last

2. Date of Birth: __ _/__ _/_ __

3. Authorization requested by: *Kathryn Montgomery, MA, LPC, NCC, CHT*_____
   Requestor

5. I authorize Requestor to converse in the case of emergency only with the following persons:
   _____
   _____
   _____

6. Purpose for this authorization is:
   _____ My request
   _____ Other (describe): _____

7. This Authorization is voluntary and use of my name as protected health information must conform to applicable law and limits described herein.

I understand that I can rescind my authorization for release at any time by notifying the Requestor in writing.

I authorize a photocopy of this document to be treated as an original when attached to a letter requesting the confidential information as described above.

I have received a copy of this two-page document describing my rights in relation to this authorization.

_____
Printed Name of Client (and Personal Representative if applicable)

_____
Signature of Client (or Personal Representative if applicable)

Date of signature: _____

HIPAA: PATIENT RIGHTS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("*HIPAA*").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address:

   Kathryn Montgomery, MA, LPC, NCC, CHT
   5460 Ward Road – Suite 210
   Arvada, CO 80002-1806

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain any treatment or payment or eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider does have the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiates this authorization, you must receive a copy of the signed authorization.