Rooted Insights, PLC

Authorization for Use and Disclosure of Protected Health Information

Patient Name: **Patient DOB:**

I hereby authorize Rooted Insights, PLC to release to and/or obtain my protected health information, as described below, from/to:

Person or Entity Name: **Address:** **City/State/Zip:** **Phone Number:** **Fax Number:**	**Purpose of Release/Disclosure:** ☐ **Transfer of Care** ☐ **Continuation/Coordination of care** ☐ **Insurance Coverage** ☐ **Legal** ☐ **SSA/Disability** ☐ **Personal Use** ☐ **Other:**_____

Information authorized to be disclosed:

- ☐ Participation in Treatment
- ☐ Diagnosis
- ☐ Psychological/Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Testing/Assessment Information
- ☐ Hospital/Provider Records/Labs
- ☐ Progress in Treatment
- ☐ Treatment Plan/Summary
- ☐ Continuing Care Plan/Summary
- ☐ Educational Information
- ☐ Billing Information
- ☐ Other: _____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS ☐ Substance Use ☐ Genetic Testing ☐ Mental Health

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Rooted Insights, PLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Rooted Insights, PLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Expiration: This authorization will expire 1 year from the date of signing or on _____(if different from 1 year).

_____ _____
Signature of Patient or Legal Representative **Date**

_____ Self
Printed Name of Patient or Patient's Representative **Relationship to Patient**
☐

Rooted Insights, PLC
2570 106th St. Ste E, Urbandale, IA, 50322
Phone: 515.446.7284
Fax: 515.349.7195