

# Vritti Integrative Psychotherapy

## Fremont

3417 Evanston Ave N  
Suite 304  
Seattle Wa 98103

## West Seattle

2600 SW Barton St  
Suite A24  
Seattle Wa 98126

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## HIPAA AUTHORIZATION FORM

I, \_\_\_\_\_, whose date of birth is \_\_\_\_\_,  
authorize \_\_\_\_\_ to disclose to and/or  
obtain from \_\_\_\_\_ the  
following information:

### Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed.)

<input type="checkbox"/> Assessment	<input type="checkbox"/> Testing Information
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Educational Information
<input type="checkbox"/> Psychosocial Evaluation	<input type="checkbox"/> Presence/Participation in Treatment
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Continuing Care Plan
<input type="checkbox"/> Treatment Plan or Summary	<input type="checkbox"/> Progress in Treatment
<input type="checkbox"/> Current Treatment Update	<input type="checkbox"/> Other _____

### Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_

### Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to \_\_\_\_\_ at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

### Expiration

Unless sooner revoked, this authorization expires on \_\_\_\_\_, or as otherwise indicated: \_\_\_\_\_

**Conditions**

I further understand that \_\_\_\_\_ will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: \_\_\_\_\_

**Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: \_\_\_\_\_

I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

\_\_\_\_\_ Check here if client refuses to sign authorization.

\_\_\_\_\_  
Signature of Staff Witness

\_\_\_\_\_  
Date

