JAMIE SCHENK DEWITT, MA, LMFT

Licensed Marriage and Family Therapist # 90492

323.424.7151 www.jamieschenkdewitt.com

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Jamie Schenk DeWitt**, **MA, LMFT # 90492** to use and/or disclose certain protected health information (PHI) about me.

This authorization permits **Jamie Schenk DeWitt** to use and/or disclose individually identifiable health information about me including: diagnostic code, date(s) of services and type of services.

The information will be used or disclosed for the following purpose: insurance billing

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information and so that my insurance can be billed. This authorization will expire at termination of treatment.

The Practice will receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Jamie Schenk DeWitt**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to **Jamie Schenk DeWitt** to the address listed above.

Signed by: _____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable Relationship to Patient