Massachusetts Department of Public Health
HIPAA Compliant "Authorization for Release of Information"

A federal law known as HIPAA (Health Insurance Portability and Accountability Act) protects the privacy of your medical information. HIPAA limits the ways doctors, pharmacies, other health care providers, health insurance companies, nursing homes, and Medicaid/Medicare can share your personal health information.

HIPAA does not allow your health care providers to share your medical information with practitioners of complimentary or alternative medicine (CAM), including hypnotists. However, you can give your hypnotist and health care providers permission to share information relevant to your hypnosis sessions by filling out an "Authorization for Release of Information" form.

If you want your Licensed Medical or Mental Health Provider to share information about you that may be relevant and useful to your hypnosis sessions with Linda E. Donalds,BCH // New Horizons in Hypnosis, please make sure that you fill out all of the sections below. This will tell us what information you want us to share and who to share it with. If you leave any sections blank, your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION 1A

I, _____ , DOB: _____, give my permission for
(Patient/Guardian/Authorized Agent) (Date of Birth)

_____ to share the information, written or oral, contained
(Licensed Medical or Mental Health Provider's Name/Organization Name)

in ☐ my file [-OR- ☐ my child's file _____ , DOB: _____],
(Child's Name) (Child's Date of Birth)

with this Person(s) or Organization:

Name:	Linda E. Donalds, BCH
Organization:	New Horizons in Hypnosis
Address:	492 Holman Street, Lunenburg MA 01462
Phone Number:	(508) 246-2721

If you are NOT the patient, please specify your relationship to the patient: _____

SECTION 1B

I, _____ , DOB: _____, give my permission for
(Patient/Guardian/Authorized Agent) (Date of Birth)

___Linda E. Donalds, BCH – New Horizons in Hypnosis___ to share the information, written or oral, contained
(Individual/Organization Name)

in ☐ my file [-OR- ☐ my child's file _____ , DOB: _____],
(Child's Name) (Child's Date of Birth)

with this Licensed Medical or Mental Health Provider or Organization:

Name:	
Organization:	
Address:	
Phone Number:	

If you are NOT the patient, please specify your relationship to the patient: _____

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SECTION 2

A. Health and Personal Information

Please describe the information you want to be share about you. Please include any dates and details you want to share.

_____
_____
_____
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B. Permission about Specific Health Information. Please write your initials on the line, only if you choose to share any of the following information:

_____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

_____ I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

_____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION 3 – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

_____
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SECTION 4 – How Long This Permission Lasts

This permission to share my information will expire in 12 months from the date this form is signed.

I understand that I have the right to inspect and obtain a copy of the information I have given permission to be disclosed by this authorization.

I understand that the person(s) or organization(s) listed in this section may or may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

I understand that I can change my mind and revoke this authorization at any time by giving written notice to my Licensed Medical or Mental Health Provider as well as to Linda E. Donalds, BCH. Written notice must be sent by postal mail (not email) or by bringing it in person to their office.

If the release of the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

I understand that it is not required for me to give permission to share my information with the person(s) or organization listed in this form.

I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, so long as this information is not required in order to determine whether I am eligible for services or to pay for the services that I receive.

SECTION 5 – Signature(s)

By signing this Authorization form, I authorize the use or disclosure of the above confidential and/or Protected Health Information from the offices shown.

Your Signature: _____ Today's Date: _____

Print Your Name: _____

If this form is being filled out for someone who is under the age of 18, please have them sign above and then the legal authority (such as a parent, a court appointed guardian or executor, a custodial parent, or a health care agent) must also sign below:

Your Signature: _____ Today's Date: _____

Print Your Name: _____ Relationship: _____

Please make 3 copies of this form – one for your Licensed Health Provider's records, one for Linda Donalds' records, and one for your own personal records.
Thank you!