Authorization for the Release of Health-Related Information
(HIPAA- Compliant Form)

_____ ____/____/_____
Please print name of patient Date of Birth

I authorize_____ (attending physician) to disclose protected health information concerning me to TriadBeHeadStrong. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and to confirm my condition as requested.

This protected health information is to be disclosed under this authorization so that TriadBeHeadStrong may offer assistance in the form of gift certificates or community assistance as available.

This authorization shall remain in force for twenty-six (26) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to: TriadBeHeadStrong, PO Box 8076, Greensboro, NC 27419.

I understand that a revocation is not effective to the extent that TriadBeHeadStrong already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information but will not be re-disclosed by TriadBeHeadStrong except as authorized by me or as required by law.

I understand that _____ (attending physician) may not refuse to provide treatment or health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my diagnosis, TriadBeHeadStrong may not be able to process my application. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ ___/___/_____
Signature Patient or Personal Representative Date

_____
Description of Personal Representative's relationship to Patient