Daystar
counseling ministries, inc.

HIPAA Privacy Authorization For Clients 16+ Years Old

Authorization for Use or Disclosure of Protected Health Information

1. I hereby authorize Daystar Counseling Ministries, Inc. to release my client records to the following recipient at the physical mailing address and/or electronic mailing address noted below:

   Recipient _____

   Recipient's Mailing Address _____

   Recipient's E-mail Address _____

2. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that (a) any person or entity has already acted in reliance on my authorization or (b) if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

3. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

5. I represent and warrant to Daystar Counseling Ministries, Inc. that I have the legal authority to sign and deliver this release, and no court order or other legal agreement prohibits me from doing so.

Signature of Client Requesting Information _____

Printed Name of Client Requesting Information _____

Date _____