RHYTHMIC HEART
MUSIC THERAPY

Additional Forms:

HIPAA Privacy Authorization Form

Media/Information Release

RHYTHMIC HEART
MUSIC THERAPY

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I, _____, authorize **Rhythmic Heart Music Therapy, LLC** (healthcare provider) to use and disclose the protected health information described below to _____ (individual/provider seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

a. □I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until one year from the date signed, at which time this authorization expires.

6. 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 any person or entity has

RHYTHMIC HEART
MUSIC THERAPY

already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

8. 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.

Responsible Party Signature: _____ Date:_____

Printed Name: _____

Relation to Client: _____

Revocation of Authorization

I revoke authorization for **Rhythmic Heart Music Therapy, LLC** (healthcare provider) to use and disclose all previously authorized protected health information to _____ (individual/provider seeking the information). This revocation is effective as of _____.

I understand to reauthorize disclosure to this party I will need to sign a new authorization.

Responsible Party Signature: _____ Date:_____

Printed Name: _____

Relation to Client: _____

RHYTHMIC HEART
MUSIC THERAPY

Media/Information Release

We are committed to maintaining confidentiality and privacy. We will not share any information about you without your written consent. In some cases, though, sharing an experience we had with you in music therapy can help to improve the overall quality of care for future music therapy clients. Because of this, we ask you to consider the following (please check what applies):

I, _____ grant Rhythmic Heart Music Therapy, LLC permission to share

- ▢ Video Footage
- ▢ Audio Recordings
- ▢ Still Image Photographs/written documentation such as quotes, poems, songs

that are taken of me during music therapy sessions if/when they are used for the following purposes:

- ▢ Educational (conference/community presentations, sharing with students, etc)
- ▢ Research (for reference and/or publication in scholarly journals, books, etc)
- ▢ Promotional (still images for use in brochures, website, etc)

Regarding the release of personal and treatment information in the above scenarios:

- ▢ I give permission to use my first name.
- ▢ I give permission to share my goal areas as applicable
- ▢ I give permission to share diagnosis and behavior in sessions as applicable

▢ I <u>do not grant</u> permission for release in any purpose or scenario.

I understand that my responses on this form will not affect my treatment in music therapy and that I am free to grant or withhold permission of any of these things to any extent I choose. I understand that my personal information will not be otherwise shared without my written consent.

This authorization shall be in force and effect until one year from the date signed, at which time this authorization expires.

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 any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

RHYTHMIC HEART
MUSIC THERAPY

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

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.

Responsible Party Signature: _____ Date:_____

Printed Name: _____

Relation to Client: _____

Revocation of Authorization

I revoke authorization for **Rhythmic Heart Music Therapy, LLC** (healthcare provider) to use if previously signed Media/Information Release. This revocation is effective as of _____.

I understand to reauthorize disclosure to this party I will need to sign a new authorization.

Responsible Party Signature: _____ Date:_____

Printed Name: _____

Relation to Client: _____