HIPAA Release Form

Mail or fax completed form to:

Address: **Beat It! Employee Assistance Programs**
20079 Stone Oak Parkway, Ste. 1105-158
San Antonio, TX 78258

Fax: 800.828.3939

Last Name	First Name		MI
Street Address	City	State	Zip
Email Address	Daytime Phone	SSN or Medical ID	

My protected health information is individually identifiable health information including demographic information collected from me or received by a health care provider, a health plan, my employer or health care clearinghouse, and relates to (i) my past, present or future mental health and/or alcohol and drug abuse; (ii) the provision of health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provision of the Health Insurance Portability and Accountability Act (HIPPA), I, the undersigned, grant permission to Beat It! Employee Assistance Programs to disclose protected health information (as defined in HIPAA) to health care providers, insurance carriers and other entities for the purpose of my health care and payment thereof:

Purpose of my authorization: ☐ At my request ☐ Inform family members ☐ Other: ____________

I may revoke this Release at any time by notifying Beat It! Employee Assistance Programs of the revocation in writing and faxed to 800.828.3939. If no revocation is requested or specified, this authorization will expire 12 months from the date of treatment discharge.

If at any time you need to alter this release form, please contact Beat It! Employee Assistance Programs at 800.828.3939.

Date (mm/dd/yyyy)	Date Authorized Effective Until (mm/dd/yyyy)
Print Name of Patient or Authorized Person	
Signature of Patient or Authorized Person	

Upon completion please print and sign this formand either mail or fax to the address at the top of this form.