Equity is Intentional.
Paperflower Foundation
3104 E Camelback Ave #2414 Phoenix, AZ 858016
Phone: 855-210-7731 Fax: 855-458-0280
info@paperflowerfoundation.org

HIPAA Authorization for Limited Disclosure of Information

Client Information

- Client Name: _____
- Date of Birth: _____
- Case ID (if assigned): _____

Authorization

I authorize [Partner Name / Practice Name] to disclose limited information to Paperflower Foundation for the sole purpose of verifying eligibility, coordinating payment, and administering charitable sponsorship of care.

Information That *May* Be Disclosed

☐ Confirmation that services were rendered
☐ Dates of service
☐ Type of service (e.g., therapy session, evaluation, medication management)
☐ Self-pay rate and amount billed
☐ Amount paid by client (if any)

Optional (De-Identified Only):
☐ Diagnosis category (not full diagnosis)
☐ Age group
☐ Zip code

No clinical notes, psychotherapy notes, or full medical records will be shared.

Information That Will *Not* Be Disclosed

The following information will not be disclosed under this authorization:

- Psychotherapy notes
- Detailed treatment records
- Substance use treatment records protected under 42 CFR Part 2 (unless separately authorized)
- HIV/AIDS status
- Genetic testing results

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Purpose of Disclosure

The purpose of this disclosure is limited to:

- Determining eligibility for financial sponsorship
- Processing invoices and payments
- Internal, de-identified impact reporting by the Foundation

Expiration

This authorization will expire on the earliest of:

- ☐ Completion of sponsored services
- ☐ One (1) year from the date signed
- ☐ Earlier revocation by the client

Right to Revoke

I understand that:

- I may revoke this authorization at any time by submitting written notice
- Revocation will not affect disclosures already made in reliance on this authorization

No Conditioning of Care

I understand that:

- My treatment, payment, enrollment, or eligibility for services is not conditioned on signing this authorization
- Refusal to sign may affect the Foundation's ability to provide financial sponsorship

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Acknowledgment

I acknowledge that:

- Information disclosed may no longer be protected by HIPAA once released, though the Foundation agrees to maintain confidentiality and limit use to the purposes stated above
- I have had the opportunity to ask questions about this authorization

Client Signature

Client Name (Printed): _____
Signature: _____
Date: _____

Authorized Provider Representative (Optional)

Provider / Practice Name: _____
Signature: _____
Date: _____

Internal Use (Paperflower Foundation)

- Date Received: _____
- Case ID Assigned: _____
- Reviewed By: _____