South Florida Psychological Associates, LLC

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(954) 909-7793

Authorization to Use and Disclose Protected Information

Client's Name: ____

DOB: ___________________________________

I, ____ , authorize South Florida Psychological Associates, LLC to:

_____ (send) ____ (receive) the following _____ (to) ____ (from)

Name: ____ Telephone: ________________________

Address: ___________ City: ____________________ State: _______ Zip: ___________

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

____ Academic testing results

____ Behavior programs

____ Progress reports

____ Intelligence testing results

____ Medical reports

____ Personality profiles

____ Psychological reports

____ Psychological testing results

____ Service plans

____ Summary reports

____ Vocational testing results

____ Entire record, except progress notes

____ *Psychotherapy Notes

____ Other, specify________________________________

The above information will be used for the following purposes:

____ Planning appropriate treatment or program

____ Continuing appropriate treatment or program

____ Determining eligibility for benefits or program

____ Case review ____ Updating files

____ Other (specify) ____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually

Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __Self __Parent/legal guardian __Personal representative

__Other (describe) ____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ____ Date: ______/_____/______

Parent/guardian/personal representative (if applicable)

Signature: ____ Date: ______/_____/______

Witness (if client is unable to sign)

Signature: ____ Date: ______/_____/______