

CAHABA PSYCHOLOGY CENTER
CHILD and ADOLESCENT INFORMATION FORM
TO BE COMPLETED BY PARENT or LEGAL GUARDIAN:

Today's Date: _____

Name and Relationship of Person Completing Form: _____

Child's Full Name: _____ SS# _____

Child is called: _____ Age: _____ Sex: Male Female

Date of Birth: ____/____/____ Present School: _____ Grade _____

Home Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____ Under whose name is this listing? _____

Cell Phone/ Beeper #: _____ Email Address _____

Brief Statement of Concerns: _____

How Did You Hear About Us? _____

Primary Care Physician: _____ Phone # _____

Child's Natural or Adopted Parents are: Living Together Separated Divorced

Father Deceased Mother Deceased Father Remarried Mother Remarried

Natural or Adopted Father's Full Name: _____

Address if different than above: _____

Natural or Adopted Mother's Full Name: _____

Address if different than above: _____

Stepfather's Full Name: _____

Address: _____

Stepmother's Full Name: _____

Address: _____

This Child Lives With: _____ Relationship to Child: _____

(If applicable, Child is in Legal Custody of: _____ Full Joint)

Family Employment

	Name of Employed Person	Place of Employment	Type of Work
1)	_____	_____	_____
2)	_____	_____	_____

Father's Work Phone: _____ Mother's Work Phone: _____

Stepfather's Work Phone: _____ Stepmother's Work Phone: _____

Siblings:

	Names	Age	Relationship	School, Grade
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

In Case of Emergency Please Contact:

Name: _____ Phone #: (____) _____ Relationship to child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

Insured _____

Insured _____

DOB _____ Employer _____

DOB _____ Employer _____

Patient's Relationship to Insured:

Patient's Relationship to Insured:

Self Spouse Child Other

Self Spouse Child Other

Authorization Number _____

Authorization Number _____

of Visits _____ CoPay _____

of Visits _____ CoPay _____

Deductible \$\$ _____ SSN _____

Deductible \$\$ _____ SSN _____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Cahaba Psychology Center. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of the first session.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

ABOUT PSYCHOTHERAPY

Individuals consult with psychologists for a variety of reasons. We will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between you and your psychologist. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. We will attempt to help you achieve your goals, but we cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, feelings of depression, self-doubt, and confusion. While we are trained, licensed and experienced psychologists, we cannot guarantee change nor can we promise that all problems will be resolved.

PROFESSIONAL FEES

The fee for an initial consultation (45 minutes) is \$160.00. During the consultation, the client and therapist together will agree on the frequency of future visits and their length, which will usually be 45 minutes (\$140.00). Longer or shorter visits may be scheduled at times, and will be charged at the rate of \$140.00 for 45 minute time segments.

Other fees:

1. Telephone consultations with you, or on your behalf, may be billed at a rate proportionate to the rate for therapy. Written communications to you or on your behalf will also be billed at a similar rate.
2. The fee for returned checks is \$30.00.
3. Any court appearance, or deposition, or the provision of documents for any attorney or for the court will be billed at a rate of \$200 per hour, and will include preparation and travel time. You will be responsible for all such fees related to your evaluation or treatment, payable at the time any such court-related services are requested.
4. Psychological assessments/evaluations are charged at the rate of \$150 per unit of time required for administration, scoring, interpretation, and report.

Payment for services is expected at time of service. You may use a credit card, check or cash to pay for these services. For those of you who have insurance coverage for mental health services, we can work with you in filing for reimbursement of the charges. If your coverage is through a managed care organization, there is a co-pay for which you are responsible. We will bill the managed care organization for the rest of the charge for that service. If you are using your insurance to help pay for our services, you are responsible for verification of coverage and for obtaining pre-authorization for these services prior to your first visit.

CANCELLATION POLICY

As clinical psychologists, we work as service providers. Therefore, as psychologists, our product is our time (and our expertise). When someone fails to appear for a scheduled appointment, we are not able to fill in that time with another client. Also, when appointments are cancelled fewer than 24 hours before the appointment, it is often difficult to fill that time as well.

If you give us 24 hours notice of your intention not to use one of your appointments, we will not charge you for the time. With such notice, we can make alternative plans. If you fail to provide a 24-hour notice, regardless of the reason for absence, then you will be charged for the scheduled time, at the full session rate. We cannot bill your insurance company for a missed appointment. If the office is closed or you are unable to get someone to answer the phone you may leave a voicemail canceling your appointment.

CONTACTING US

Our office hours are as follows:

8:30 a.m. to 5:00 p.m., Monday through Thursday

8:30 a.m. to 3:00 p.m., Friday

Closed for lunch daily 12 noon to 1:00 p.m.

For emergencies after hours, we can be reached through the following numbers:

Dr. Mark Burge 205-447-4255

Dr. Gayle Janzen 205-960-9342

Dr. Patricia Jolly-Fleece 205-533-0851

If you are unable to reach us and feel that you cannot wait for one of us to return your call, contact your family physician or the nearest emergency room, and ask for the psychiatrist on call. If one of us will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If the Alabama Board of Examiners in Psychology is requesting the information for an investigation of our practice, we are required to provide it for them.
- If a patient files a complaint or lawsuit against one of us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, we may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we know or suspect that a child under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
- If we know or suspect that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
- If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, we will make every effort to fully discuss it with you before taking any action and we will try to limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, test results, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your records, except in unusual circumstances that involve danger to you or others. In those situations, you have a right to have your record sent to another mental health provider. In most situations, we are allowed to charge a copying fee of \$1.00 (one dollar) per page (and certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we may also keep a set of Psychotherapy Notes. These notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that such disclosure would be reasonably likely to be detrimental to your health.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

MINORS & PARENTS

For therapy with children under the age of 14, it is our policy to request an agreement in which parents (or guardians) consent to give up access to the child's records. If a diagnostic evaluation or assessment is requested, we will discuss findings, results, and treatment plans with you. Most of the minors we see are brought voluntarily by their parents and come with parental knowledge. In such circumstances, parents are often understandably curious about the treatment of their children. It is our position, however, that young people need to develop trust in their therapist and need some degree of security and privacy. Therefore, we specifically request that you limit your inquiry about the details of their therapy. We need you to know that we will, indeed, bring to your attention matters that we believe are important for you to know, and we request that you trust our judgment about this important issue. We also hope that you will refrain from asking your child what has transpired in therapy or diagnostic sessions.

If your child is 14 or over, we cannot discuss anything about evaluation or treatment with you without the written Authorization from your child.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, and the accompanying Authorization, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE

Printed name of Patient _____

Signature of Patient (Parent or legal guardian, if child is under age 14)

Date signed

Witnessed by

Date witnessed

Revised 06/2011

Cahaba Psychology

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Here are some definitions of terms that will be helpful in understanding this Notice:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

I. Uses for Treatment, Payment, and Health Care Operations

We may use your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. The “consent” is given when you sign the Psychotherapist-Patient Services Agreement.

II. Disclosures Requiring Authorization

We may disclose PHI for purposes of treatment, payment, or health care operations with your Authorization. We may also disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission for specific disclosures, above and beyond the general “consent.” In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we know or suspect that child is a victim of child abuse or neglect, we are required to report the abuse or neglect to a duly constituted authority.
- *Adult and Domestic Abuse* – If we have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, we must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the Alabama Board of Examiners in Psychology is conducting an investigation into our practice, then we are required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization from you or your legally appointed representative or a court order. The privilege

does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – We may disclose PHI to the appropriate individuals if we believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- *Worker's Compensation* – We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless we make a clinical determination that access would be detrimental to your health. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

All requests for restrictions, communications, information, inspection, accounting, amending, and copying will be done in writing.

Psychologist's Duties:

- We are required by law to maintain the privacy of protected health information regarding you and to provide you with notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post the Notice on the office bulletin board and on website (www.cahabapsychology.com).
- A copy of the Notice is available on request.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact your psychologist at this office. Each psychologist serves as the Privacy Officer for her own patients .

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We will limit the uses or disclosures that we will make to the minimum necessary.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting it on the office bulletin board, and on our website (www.cahabapsychology.com). A copy is available on request.

Revised 06/03

Cahaba Psychology Center

Questions to ask your insurance company before your first visit with us:

What are my mental health (Mental and Nervous) benefits?

Insurance Company for Mental Health Coverage (may be different from your major medical coverage) _____

What is my yearly deductible? \$ _____

How much of my deductible has already been met? \$ _____

Does it start over each calendar year? Yes No

If not, what is the renewal date? _____

What is my copay/percentage once the deductible has been met?
_____ percent of _____ or \$ _____ copay

Is there authorization required? Yes No

If so,

Authorization number: _____ # visits _____

How many visits does my insurance cover in a year? _____

Where should my mental health claims be mailed?

Additional comments or information:

NOTE: Your insurance will not cover any charges for missed appointments.

**Cahaba Psychology Center
2 Riverchase Office Plaza, #115
Birmingham, Alabama 35244
(205) 403-0955 Fax (205) 403-0956**

Protected Health Information Consent Form

Patient's name: _____ DOB: _____

My permission is granted to _____ to

- Release protected health information to:
- Exchange protected health information with:
- Obtain protected health information from:

The following information may be included in this release:

- | | |
|--|---|
| <input type="checkbox"/> Clinical Intake | <input type="checkbox"/> Teacher's observations, progress notes |
| <input type="checkbox"/> Consultation | testing; achievement scores |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Emergency Notification |
| <input type="checkbox"/> Medication Rx | <input type="checkbox"/> Treatment Plan/ Outpatient Treatment Request |
| <input type="checkbox"/> Psychological/Psychiatric Evaluation | <input type="checkbox"/> Dates of Service |
| <input type="checkbox"/> Psychological/Psychiatric Treatment Records | <input type="checkbox"/> Other _____ |

The purpose of this disclosure is:

- | | |
|---|---|
| <input type="checkbox"/> To facilitate evaluation and treatment | <input type="checkbox"/> For disability determination |
| <input type="checkbox"/> For legal purposes | <input type="checkbox"/> For insurance purposes |
| <input type="checkbox"/> For other: _____ | |

This authorization will be valid for a period of One (1) year unless it is revoked prior to that time.

I hereby release _____ and _____ from any and all liabilities arising from but not limited to the laws of the state of Alabama and/or any other states related to the disclosure of confidential or privileged information.

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining as insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information of your information and no longer protected by the HIPPA Privacy Rule.

Patient Signature (Parent or legal guardian if patient is a minor or incapable) Date _____

Signature of Parent Legal Guardian Legal Representative Date _____

Witness Date _____