Easton Neuropsychology and Behavioral Services, LLC

299 Industrial Drive, Nazareth, PA 18064 (610) 504-6122

Standard Authorization
Mental Health Treatment

I, ______________________________, whose Date of Birth is ________________,

authorize Easton Neuropsychology and Behavioral Services, LLC, to disclose to and/or obtain from:

____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

_____ Diagnosis
_____ Assessment
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information
_____ Treatment Summary
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Demographic Information
______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______Other_______________________
______Other_______________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than as described or as specified above, please specify:

____
____
____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Easton Neuropsychology and Behavioral Services, LLC, at 299 Industrial Dr., Nazareth, PA 18064. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: ________________ or as otherwise indicated:____

Conditions

I further understand that Easton Neuropsychology and Behavioral Services, LLC, will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ____

____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

____

Signature of Patient/Client Date

____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____

Signature of Staff Witness Date