

Jonina D. Bolton, Ph.D.
Licensed Psychologist

Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information for:

Printed Name: _____ **Date of Birth:** _____

1. I authorize this person or organization: **Jonina D. Bolton, Ph.D., Licensed Psychologist**
2. To use, disclose or receive the following information: (please initial)
_____ Psychological evaluation(s), reports, assessments, treatment notes, summaries, documents with diagnoses, prognoses, recommendations and behavioral observations/checklists completed by staff members or the patient, or similar documents.
_____ Complete copy of the medial record and the folder in which it was kept.
_____ Phone Consultation pertaining to current or prior services, including impressions about assessment, treatment, diagnoses, and/or prognoses.
_____ Other: _____
3. Dates of care included: From _____ to _____
4. To or from this person or organization: _____

5. The information will be used/disclosed for the following purposes: _____

6. I understand and agree that this Authorization will be valid until the following date or event, upon which this Authorization expires: **One year (12 months) following termination of treatment/evaluation**. I understand that after that date or event, no additional information can be used or released to this person/organization unless I sign a new Authorization like this one.
7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any disclosures after the date that it is received but cannot change the fact that some information may have been sent or shared before that date.
8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the professional/facility listed nor will it affect my eligibility for benefits.
9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
11. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.
12. Signature of client or client representative: _____
Printed name of client or personal representative: _____
Description of personal representative's authority: _____ Date: _____
13. I acknowledge that I have received a copy of this completed form. (Please initial here). _____
14. I, a mental health professional, have discussed the issues above with the client and/or his or her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of professional

Jonina D. Bolton, Ph.D.
Printed name of professional

Date