The Levin Center

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Pediatric Neuropsychologist
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Name of Patient:_____

1. I authorize the healthcare practitioner **Juliana Bloom, Ph.D.** (the 'Practitioner") to disclose my (or my child's or my ward's) protected health information, as specified below, to **[name and address of person/entity to receive information]**:

_____
_____
_____

2. I am hereby authorizing the disclosure of the following protected health information:

_____assessment and diagnosis
_____treatment plan
_____treatment summary/discharge summary
_____full neuropsychological report

3. This protected health information is being used or disclosed for the following purposes:

_____school consultation
_____coordination of care
_____other (please specify):

4. I specifically authorize the disclosure by the healthcare practitioner of the following types of protected health information by placing my initials where appropriate below, my initials serving as my signature release for each type of specially protected health information:

_____Psychotherapy Notes (as defined by HIPAA)
_____Confidential HIV Related Information [1]
_____Alcohol/Substance Abuse Treatment Information [2]

5. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

6. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that information disclosed pursuant to this authorization may be disclosed by the

recipient and may no longer be protected by HIPAA or any other federal or state law, provided

however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not re-disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

8. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient

Date

_____

Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient (if a Personal Representative, also state relationship to patient)