NORTHWEST NEUROBEHAVIORAL HEALTH, LLC

Authorization for Use and Disclosure of Protected Health Information: Doctor

Please note that this form must be filled out completely to be valid.

Patient: _____ Date of birth: _____

Parent/Guardian: _____ Phone number: _____

I, and/or my parent/guardian, authorize:

Name/Title/Organization: Northwest Neurobehavioral Health

Address: 2463 E Gala St Suite 100 Phone: _____

Meridian, ID 8370 Fax: _____

Check either/both as needed

To release information to: ( ) To obtain information from: ( )

Name/Title/Organization: _____

Address: _____ Phone: _____

_____ Fax: _____

The following information:

____ Speech Evaluation

____ OT Evaluation

____ Physician Note

____ Treatment Plan(s)

____ Psychological Evaluation

____ Neuropsychological Evaluation

____ ASD Clinic Evaluation

____ Participation in Treatment

____ Intake Evaluation/CDA

____ Medication Management

____ Other (please specify in space below)

_____

_____

From/To date: _____

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.

Conditions: I understand that Northwest Neurobehavioral Health, 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 consequences including, but not limited to, impacting the outcome of coordinated care.

Please note: Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Northwest Neurobehavioral Health, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

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 directly.

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 HIPPA privacy regulations, unless a State law applies that is more strict than HIPPA and provides additional privacy solutions.

Expiration: Unless sooner revoked, this authorization expires one year from the signed date, or as otherwise indicated: _____ (cannot exceed one year).

Signature of Patient (If 14+ Years of Age Date

Signature of Parent or Guardian Date

www.nnhidaho.com 2463 East Gala St Suite 100, Meridian, ID 83642

Phone: (208) 955-7333 Fax: (208) 955-7330

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse individual.