

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)

- _____ Treatment Summary
- _____ Complete Copy of the Medical Record and all PHI, with the exception of psychotherapy notes.
- _____ Psychotherapy Notes.
- _____ Psychological Evaluation(s), including reports, assessments, behavioral observations/checklists or similar documents completed by Dr. Bolton or the patient, diagnoses, prognosis and/or recommendations.
- _____ Phone Consultation pertaining to current or prior services, including impressions about symptoms, assessment, treatment, diagnoses and prognosis.
- _____ 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 ("at the request of the individual" can be utilized if you are Dr. Bolton's patient and you do not want to state a specific purpose): _____

- 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 written notification to Dr. Jonina D. Bolton. However, my revocation will not be effective to the extent that Dr. Bolton has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If I revoke this authorization, then 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 Dr. Bolton, nor will it affect my eligibility for benefits, unless the services are provided to me for the purpose of creating health information for a third party.
- 9. 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 the HIPAA Privacy Rule.
- 10. I understand that I may request to inspect or have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
- 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). _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her personal representative. My observations of 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