Aristotle's Psychological and Biofeedback Services

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HIPAA AUTHORIZATION FORM

I, ____________________________________, whose date of birth is ______________________, authorize ____ to disclose to and/or obtain from ____ the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Progress in Treatment
____ 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 other purpose, please specify: ____

I will be given a copy of this auhorization for my records.

____
Signature of 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.

____

____
______ Check here if client refuses to sign authorization.

____
Signature of Staff Witness Date