Empowered Minds Neuropsychology PLLC
Authorization to Disclose Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Date of Birth (MM/DD/YYYY):	Phone:	Email Address:	
Street Address:	City:	State:	Zip:

I authorize and request Empowered Minds Neuropsychology PLLC ("Practice") to exchange (disclose and receive) the patient's health information designated below ("Health Information") with the following individual(s), provider(s), and/or entity(ies):

Name of Person and/or Agency

_____

Address

_____

Phone **Fax**

_____ _____

The Health Information that the Practice may send and receive is the following: (*check only one box*)*:*

☐ All Health Information about me in my medical record created or maintained by the Practice and the individual(s), provider(s) and entity(ies) named above. This information may include, if applicable:
- Information about diagnosis and treatment of mental health conditions.
- Information about HIV/AIDS testing and treatment.
- Information about diagnosis and treatment of sexually transmitted disease(s).

☐ All Health Information about me as described in the preceding checkbox, *excluding* the following: _____

_____

☐ Specific Health Information *including only*: _____

_____

I understand that the Health Information disclosed and/or re-disclosed pursuant to this Authorization is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR parts 160 and 164), and applicable state confidentiality laws. HIPAA prohibits the unauthorized disclosure of your Health Information.

Purpose: The purpose for the disclosure of my Health Information under this Authorization is: *(check only one box):*

☐ Treatment ☐ Payment ☐ Legal ☐ Research ☐ Insurance ☐ Employment ☐ School

☐ Other purpose: _____

Expiration: This Authorization will expire one year from the date signed unless another event or date is specified below:

Other event or date: _____

Other Important Information: I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that my revocation is not effective to the extent that any person or entity has already acted in reliance on the Authorization. I understand that I might be denied services if I refuse to authorize disclosure of my information for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to the disclosure of my information for other purposes. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I am entitled to receive a copy of this signed Authorization. If I am the personal representative of the minor patient, I certify under penalty of perjury of the laws of Washington State that I am the legally authorized personal representative of the patient named in this authorization, and that I have the legal authority to act on behalf of the minor patient regarding the use and disclosure of the minor's Health Information.

_____ _____ _____

Signature of Patient or Legally Authorized Representative Date Time

_____

Printed Name of Legally Authorized Representative (if applicable)

_____

Relationship to Patient (e.g. parent, legal guardian, etc.) (if applicable)