AUTHORIZATION AND CONSENT FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

You have the right to refuse to sign this authorization. Treatment will not be withheld if you refuse to sign the authorization.

Name: _____ DOB: _____

I, the above named or legal representative of the above named, hereby authorize and request the following provider (name and contact information):

Baylor University Psychology Clinic

801 Washington Ave, Waco, TX

(254) 710-2470

to disclose/use/receive protected health information about me to/from (name and contact information):

_____

_____

_____

The disclosure/use is for the following information and/or purpose(s): (initial all that apply)

_____ test results
_____ clinical diagnoses
_____ treatment history
_____ social history
_____ progress notes

_____ to assist with treatment planning/placement
_____ to discuss my treatment with my family
_____ to assist with educational planning/placement
_____ to assist with benefits application(s)
_____ to assist with legal proceedings
_____ to assist with custody determination

_____ other: _____

If I am signing as a parent/guardian/managing conservator of a minor or guardian of an adult, I understand the information disclosed/used/received may contain reference to my family or me.

NOTE: Except for information related to alcohol or drug abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient.

I also authorize the disclosure/use/receipt of my health information regarding:

- ☐ HIV/AIDS
- ☐ Alcohol and drug abuse treatment

I understand that I have the right to revoke this authorization at any time. To do so, I must deliver a written statement signed by me to the provider which specifies the date and purpose of this authorization and my intent to revoke it. My revocation will be effective the date it is received except to the extent that information has already been used or disclosed based upon my authorization. Unless revoked earlier, this authorization will expire on: _____

_____ _____

Signature of individual or representative Date

_____

Relationship to client