Karner
Psychological
Associates

2280 Western Avenue
Guilderland, NY 12084
Ph: (518) 456-5056 FAX: 518 456-6512

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to authorize and allow the use and sharing of protected Health information about: _____

Printed Name Date of Birth

2. I hereby authorize Karner Psychological Associates or it's designated mental health professional to use or disclose the following information (**Check all that apply**):

☐ Treatment records for psychological, psychiatric or emotional illness.

☐ Admission or discharge summaries.

☐ Psychological or Social Work evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any *KPA* therapist or psychologist, or the patient, or similar documents.

☐ Treatment, recovery, rehabilitation, aftercare plans or other similar plans.

☐ Social, family, educational and vocational histories.

☐ Progress or "case" notes, or similar notes.

☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and complete tasks or activities of daily living.

☐ Billing records.

☐ Academic and educational records, including achievement and other test results, reports of teachers' observations, and other school or special education documents.

☐ HIV-related information and drug and alcohol information contained in *KPA* records will be released under this authorization unless indicated here. ☐ **Do not release these records.**

☐ Complete copy of the KPA record and the folder in which it was kept.

☐ Other:_____

3. Dates of care included: From: _____ to _____

(This will expire in one year)

Karner
Psychological
Associates

2280 Western Avenue
Guilderland, NY 12084
Ph: (518) 456-5056 FAX: 518 456-6512

4. I authorize the use/disclosure of the information noted above ____ to ____ from

_____ and/or _____

Name of person/organization Name of person/organization

5. The information will be used/disclosed for the following purpose(s):

_____

_____

6. I understand that this Authorization will be valid and in effect until _____.

I further understand that after that date or event, no more of my information can be used or disclosed to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this Authorization by sending a letter to the *KPA* Privacy Officer. If I do so, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been disclosed 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 abilities to obtain treatment from *KPA*.

9. I understand that I may inspect and have a copy of the information described in this Authorization and that there may be a cost for this copy or other services associated with producing my copy. □ Does not apply.

10. I understand that if the person or entity that receives the authorized information from KPA is not a health care provider or health insurance plan covered by federal privacy regulations (HIPPA), the information described above may be re-disclosed and is no longer protected by HIPPA regulations.

I affirm that everything in this Authorization Form that was not clear to me has been explained and I believe I now understand all of its provisions.

Karner
Psychological
Associates

2280 Western Avenue
Guilderland, NY 12084
Ph: (518) 456-5056 FAX: 518 456-6512

_____ _____

Signature of patient or his/her personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient

_____

Description of personal representative's authority

☐ I acknowledge that I have received a copy of this signed, completed form.

I, a mental health professional, representing Karner Psychological Associates. have discussed the issues above with the patient and/or his/her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____

Signature of KPA professional Printed name of professional Date