NORTHWEST NEUROBEHAVIORAL HEALTH, LLC

PROTECTED HEALTH INFORMATION RELEASE ACCESS REQUEST FORM

I hereby authorize Northwest Neurobehavioral Health, LLC to disclose **AND/OR [circle one]** receive records for:

Patient/Client name: _____ DOB: _____

From/To: _____ Phone: _____

Address: _____ Fax: _____

The following information: [Check all that apply]

_____ Speech Evaluation ____ Psychological Evaluation ____ Presence/Participation in Treatment

_____ OT Evaluation ____ Neuropsychological Evaluation _____ Intake Evaluation/CDA

_____ Physician Note ____ ASD Clinic Evaluation _____ Other _____

_____ Treatment Plan (s)

Conditions- I understand that Northwest Neurobehavioral Health, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have consequences including, but not limited to impacting the outcome of coordinated care.

Please Note- Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

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.

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Northwest Neurobehavioral Health, LLC at 2076 S. Eagle Rd. Meridian, Id. 83642. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Form of Disclosure- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration- Unless sooner revoked, this authorization expires on the following date: _____, or as otherwise indicated:_____.

_____ _____

Signature of Patient/Client (If 14+ Years of Age) 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, for example; power of attorney, healthcare surrogate, etc.)

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