ViewPoint
Psychological Services

Fort Thomas office: 1455 South Fort Thomas Avenue, Fort Thomas, KY 41075
Crestview Hills office: 2865 Chancellor Drive, Suite 100, Crestview Hills, KY 41017
Florence office: 7699 U. S. Highway 42, Florence, KY 41042
Phone: 859-442-8439 ♦ **Fax:** 859-781-0123 ♦ www.viewpointpsych.com

Authorization to Use & Disclose Protected Health Information
HIPAA Compliance Program

I am completing this form to all the use and sharing of protected health information about:

Print Name: _____ Date of Birth: _____

I authorize and give this consent voluntarily that information concerning myself or my child be released as outlined below. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing this information. I also understand that the provision of services is not contingent on my decision concerning this release of information.

☐ Please release information to:
Viewpoint Psychological Services
1455 South Fort Thomas Ave.
Fort Thomas, KY 41075
From: _____
_____

☐ I want information released from:
Viewpoint Psychological Services
1455 South Fort Thomas Ave.
Fort Thomas, KY 41075
To: _____
_____

I authorize Viewpoint Psychological Service to use or disclose the following information:

- ☐ All of the below
- ☐ Inpatient or outpatient treatment records for physical or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- ☐ Admission and discharge summaries.
- ☐ Psychological 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 staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- ☐ Social, family, educational, and vocational histories.
- ☐ Progress, nursing, case or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Vocational evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement and other test results, reports of teacher observations, and all other school or special education documents.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless otherwise indicated.
- ☐ Complete copy of the medical record.
- ☐ Other: _____

I understand and agree that this authorization will be valid and in effect until _____. I understand that after that date or event, no more of this information can be used or released to Viewpoint Psychological Services, unless I sign a new authorization form. I can revoke consent at any time.

Prohibition of Redisclosure: This information has been disclosed to you from records where confidentiality is protected by federal law. Federal regulation prohibits you from making any further disclosure of this information without the specific written consent of the person whom it pertains or as otherwise permitted by federal regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any uses of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____
Signature of Client/Representative Date

_____
Print Name Relationship to Client

I, a mental health professional, have discussed the issues above with the client and/or representative. My observations or his or 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 Mental Health Professional Print Name Date