CONNECT PSYCHOLOGICAL SERVICES, LLC

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used when authorization is required and complies with HIPAA Standards.

Print Name of Client: _____

I authorize: CPS, LLC / Dr. Karen O'Keeffe **to use or disclose the following health information.**

☐ - All of my health information

☐ - My health information relating to_____

☐ - My restrictions_____

☐ - Other: _____

The above party may disclose and exchange health information with:

Name/ organization/contact information_____

The purpose of this authorization is (check all that apply):

☐ - At my request. ☐ -Coordination of my care. ☐ - Other: _____

This authorization is permitted: On (date)_____ to _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re- disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

A copy of this authorization is as valid as the original and a copy is provided at my request.

I hearby release Connect Psychological Services/Dr. Karen O'Keeffe from any and all legal responsibility or liability that may arise from the disclosure or release of information, psychotherapy records, or portions therof, including liability for violation of the right of having this information maintained in confidentiality and privacy.

Signature of Client: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor. ☐ - Patient is unable to sign because:_____

Signature of Authorized Representative: _____Date: _____

Print Name: _____Representative is: ☐ - Parent ☐ - Legal Guardian

Signature of Witness:_____ Date:_____

Dr. Karen O'Keeffe Licensed Clinical Psychologist

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