AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Client____ Date of Birth____________________

This form authorizes the transfer of protected health information between the University of Nebraska-Lincoln Barkley Speech-Language and Hearing Clinic and the parties listed below. The protected health information may be in the form of written reports, email messages, faxes, phone conversations, or face-to-face meetings. The purpose of this release of information is: ____ ("at request of patient" is adequate for this blank)

Circle Appropriate Instruction

Send To Receive From Agency, School, Person____________________________________ Phone________________

Address, City, State, Zip____

Send To Receive From Agency, School, Person____________________________________ Phone________________

Address, City, State, Zip____

Send To Receive From Agency, School, Person____________________________________ Phone________________

Address, City, State, Zip____

Send To Receive From Agency, School, Person____________________________________ Phone________________

Address, City, State, Zip____

I authorize the Barkley Clinic to disclose the following specific information: (check all that apply)

____Psychological Evaluation ____Speech-Language Evaluation ____Treatment Records ____Medical Records
____Educational Evaluation ____Audiological Evaluation ____Academic Records ____All Records

I specifically authorize the Barkley Clinic to disclose sensitive information that may be related to: (check all that apply)

____Acquired Immunodeficiency Syndrome (AIDS) ____Psychiatric, psychological, or behavioral treatment (excluding psychotherapy notes)
____Human Immunodeficiency Virus (HIV) ____Alcohol or drug treatment

This authorization shall remain in effect for one year from the date of signature (or until___________________________)

I understand:

- I can withdraw this authorization at any time, with a written request delivered to the Barkley Clinic.
- If the Barkley Clinic has already released my health information with my authorization, withdrawing my authorization later on will not be enough to keep it confidential from parties it was already sent to.
- Services at the Barkley Clinic are not contingent upon my signing this authorization.
- Information used or disclosed based on this authorization may be subject to further disclosure by the recipient of your health information and no longer protected by the HIPAA Privacy Rule.
- This form may be duplicated and/or faxed to the parties named above for the purpose of requesting records.

______________________________________ ______________________________________
Signature of Client or Authorized Representative **Date**

______________________________________ ______________________________________
Relationship to Client **Witness**

tm 7/06