CLIENT INFORMATION SHEET (CHILD/ADOLESCENT)

Name of child/adolescent: _____ Referred by: _____

Date of Birth: _____/_____/_____ Age: _____ Insurance CO: _____

Address: _____ Insurance ID: _____

_____ Insurance CO. phone #: _____

City Zip Family Doctor: _____

Home phone: (_____) _____ Address: _____

E-mail: _____ _____

Cell phone: (_____) _____ _____

Parent's employer: _____ Medications taken: _____

Office phone: (_____) _____ Medication allergies: _____

Parent's marital status: _____ _____

Names of parents: _____ Medical conditions: _____

Name of legal guardian: _____ Previous therapy: _____

Names and ages of siblings: _____

Names of others living in the home & relationship: _____

Reason for seeking therapy at this time: _____

Please read and sign: Each individual and family session is 45 to 55 minutes. Co-payments are due each visit. You are ultimately responsible for all fees for services if your carrier does not pay a claim. If you must cancel an appointment, please provide at least 48 hour notice- because this time is reserved for you. A session that you did not attend, cannot be charged to the insurance company for reimbursement. There is a fee of $40 for appointments that were not cancelled 48+ hours in advance. Please be aware that this does not apply for group sessions. You are responsible for all group sessions whether you are able to attend or not. The fee for a missed group session is also $40.

Release of Information: I hereby give permission for Grunblatt Psychology and Counseling Offices, P.C. and my insurance carrier and the primary care physician to share information regarding my child's treatment. I permit a copy of this to be used in place of the original.

_____ _____/_____/20_____

Signature Date

I hereby give permission for Grunblatt Psychology and Counseling Offices, P.C. and _____

To share information regarding my child's academics, behavior and treatment. (Name of school)

_____ _____/_____/20_____

Signature Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

The following is the Notice of Privacy Practices of Grunblatt Psychology and Counseling Offices, P.C. HIPAA is a federal law that requires us to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to your protected health information. We are required by law to abide by the terms of this Notice of Privacy Practices.

Your Protected Health Information

Your "protected health information" (PHI) broadly includes any health information, oral, written or recorded, that is created or received by us, other healthcare providers, and health insurance companies or plans, that contains data, such as your name, address, social security number, and other information, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Protected Health Information

Generally, we may not "use" or "disclose" your PHI without your permission and must use or disclose your PHI in accordance with the terms of your permission. "Use" refers generally to activities within our office. "Disclosure" refers generally to activities involving parties outside of our office. The following are the circumstances under which we are permitted or required to use or disclose your PHI. In all cases, we are required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required.

Without Your Written Authorization

Without your written authorization, we may use within our office, or disclose to those outside our office, your PHI in order to provide you with the treatment you require or request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use within our office by our professional staff for the provision, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using the benefits of your contract with your health insurance plan, we will disclose to your health plans or plan administrators, or their appointed agents, PHI for such plan or administrators to determine coverage, for their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and for adjudication of health benefit claims; (b) disclosures for billing for which we may utilize the services of outside billing companies and claims processing companies with which we have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts, collection agencies and consumer reporting agencies, of information necessary for the collection of our unpaid fees, provided that we notify you in writing prior to our making collection efforts that require disclosure of your PHI.

Health care operations include: (a) use within our office for training of our professional staff and for internal quality control and auditing functions (b) use without our office for general administrative activities such as filing, typing, etc.; and (c) disclosures to our attorney, accountant, bookkeeper, and similar consultants to our healthcare operations, provided that we shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

PLEASE NOTE THAT UNLESS YOU REQUEST OTHERWISE, AND WE AGREE TO YOUR REQUEST, WE WILL USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

As Required by Law

We may use or disclose your PHI to the extent that such use or disclosure is required by law. Examples of instances in which we are required to disclose your PHI include: (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective services agencies; (b) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary to protect you or others from a serious imminent risk of danger presented by you; (e) for worker's compensation claims, and (f) as required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulations, including those regarding government programs providing public benefits.

All Other Situations, With Your Specific Written Authorization

Except as otherwise permitted or required as described above, we may not use or disclose your PHI without your written authorization. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to content a claim under the policy.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as record of communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only released with your specific written authorization except in limited instances, including: (a) if you sue us or place a complaint, we may use Psychotherapy Notes in our defense; (b) to the United State Department of Health and Human Services in an investigation of our compliance with HIPAA; (c) to health oversight agencies for a lawful purpose related to oversight of our practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review, or on reviewing, Psychotherapy Notes.

Your Rights with Respect to Your Protected Health Information

Under HIPAA, you have certain rights with respect to your PHI. The following is an overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions on Use or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your protected healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. We require that all requests for restrictions be in writing and that you state a reason for the request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations

We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations. We will ask you how you wish us to communicate with you.

Right to Inspect and Copy Your Protected Health Information

You have the right of access in order to inspect, and to obtain a copy of your PHI, except for (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, (c) health information maintained by us to the extent to which the provision of access to you is at our discretion, and we exercise our professional judgement to deny you access, and (d) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

We require written requests for copies of your PHI; they should be sent to our Privacy-Security Office at the mailing address below. If you request a copy of your PHI, we will charge a fee for copying. We reserve the right to deny you access to and copies of all or certain PHI as permitted or required by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or complaint.

Right to Amend Your Protected Health Information

You have the right to request that we amend your PHI, for as long as your medical record is maintained by us. We have the right to deny your request for amendment. We require that you submit written requests and provide a reason to support the requested amendment.

If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us and/or the Secretary of the U.S. Department of Health and Human Services. (DHHS). If we accept your request for amendment, we will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of yours prior to amendment and persons that we know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendments shall be sent to our Privacy-Security Office at the mailing address below.

Right to Receive an Accounting of Disclosures of Your Protected Health Information

You have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization, that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of such disclosures for a period of time less than six (6) years from the date of the request. We require that you request an accounting in writing on a form that we will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to other healthcare provided involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions,

and (g) with respect to disclosures occurring prior to 4/14/2003. We reserve the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period. All request for an accounting shall be sent to our Privacy-Security Officer at the mailing address below.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Please submit any complaint to us in writing by mail to our Privacy-Security Officer at the mailing address below. A complaint must name the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice of Privacy Practices. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Notice of Privacy Practices

We reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, we will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, or changes in the law affecting this Notice of Privacy Practices, by mail or electronically within 60 days of receipt of your request.

Ongoing Access to Notice of Privacy Practices

We will provide you with a copy of the most recent version of this Notice of Privacy Practices at any time upon your written request sent to our Privacy-Security Officer at the mailing address below. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact us at the address, telephone number, or e-mail address listed below.

To Contact Us

This is our contact information referred to above.

Our Privacy-Security Officer is: Andrea Grunblatt, Ph.D. Our mailing address is: 124 Green Street, Kingston, NY 12401. Our telephone number is: (845) 331-3001. Our fax number is: (845) 335-4600. Our email address is: staff@grunblattpsychology.com

Acknowledgment of Receipt of Notice of Privacy Practices of

Grunblatt Psychology and Counseling Offices, P.C.

I hereby acknowledge that I have received the Notice of Privacy of Privacy Practices of **Grunblatt Psychology and Counseling Offices, P.C.**

_____ _____

Patient Signature **Date**

_____

Print Name

Office Use Only

Acknowledgement of Receipt of Notice of Privacy Practices was not obtained from patient due to:

_____ Patient refusal

_____ Patient lack of understanding

_____ Emergency

_____ Other: specify

Patient _____ was ____ was not offered, ____ did ____ did not accept, a copy of Written Notice of Privacy Practices

Explanation:

Staff Name: _____ Staff Signature: _____

Date: _____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, Grunblatt Psychology and Counseling Offices, P.C., assume that we may contact you by telephone at your home, cell and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

☐ At my home telephone number: _____
_____ You can leave messages with detailed information
_____ Leave message with call-back number only
_____ Call only at specified times of day: _____

☐ At my work telephone number: _____
_____ You can leave messages with detailed information
_____ Leave message with call-back number only
_____ Call only at specified times of day: _____

☐ At my cell phone number: _____
_____ You can leave messages with detailed information
_____ Leave message with call-back number only
_____ Call only at specified time of day: _____

☐ **SEND APPOINTMENT CONFIRMATION E-MAILS:** _____

☐ In writing at:

___ My home address
___ My work address
___ Fax number: _____

☐ Other (Specify): _____

_____ _____
Signature of Patient Date

_____
Print Name

CREDIT CARD GUARANTEE OF PAYMENT

I understand that Grunblatt Psychology and Counseling Offices, P.C. will bill my health insurance company for therapy or evaluation services. I also understand that I am responsible for all reasonable and customary fees that my insurance does not pay, such as deductible, co-pays, termination of benefits, or missed appointment fees.

Grunblatt Psychology and Counseling Offices, P.C. bills insurers as a courtesy to me, rather than my paying up front and my waiting to receive insurance reimbursement. I understand that Grunblatt Psychology and Counseling Offices, P.C. will wait a reasonable period of time to be paid by my insurer for psychological services rendered. Sometimes insurance companies do not pay promptly or do not pay the amounts we initially expected. Because of this, I give Grunblatt Psychology and Counseling Offices, P.C. permission to charge my credit or debit card for any services that remain unpaid 90 days after billing. If my insurer has not paid the billed claims within 60 days, Grunblatt Psychology and Counseling Offices, P.C. will send written notice to me that they have not been paid by my insurer, and encourage me to contact the insurer to pay without delay.

I understand that Grunblatt Psychology and Counseling Offices, P.C. used the credit card company Square, Inc. On my card statement the charge will appear as if coming from that company and not from Grunblatt Psychology and Counseling offices, P.C. I agree that this form is valid for three (3) years unless I cancel the authorization in writing.

_____

Patient Name

_____

Cardholder Name (If different from patient)

_____

Cardholder billing address

Please circle type of card (Visa, Mastercard, Discover or Amex) (Credit or debit)

_____ _____

Card Number and **3-digit code on back** Expiration Date

_____

Cardholder signature and date

CONSENT FOR PSYCHOLOGICAL SERVICES FOR MINOR

Name of Person Giving Consent: _____

Your Relationship to Child (check one):

[ ] Parent [ ] Stepparent [ ] Grandparent

[ ] Guardian [ ] Other: _____

Name of Child: _____ Date of Birth: _____

I, _____ consent to the following psychological services for the child named above:

Check and Initial All That Apply

[ ] Clinical Interview/Evaluation
[ ] Counseling/Psychotherapy
[ ] Other: _____

_____ _____

Signature of person giving consent Date

_____ _____

Signature of person giving consent Date

GRUNBLATT PSYCHOLOGY AND COUNSELING OFFICES, P.C.

ANDREA GRUNBLATT, PH.D, CGP, FAGPA, RPT-S

LINA HERNANDEZ, PSY.D., LCSW-R
SHARON MCLENNON-WIER, PH.D., MSED., CRC, LMHC
NANCY CLARK, LCSW-R
JULIE DOMEIER, LCSW-R
CHRISTINE CURRY TUTHILL, LMHC
PAUL THURMAN, LMHC
JENNIFER PLUMLEY, MS, MT-BC
AMY LOWENHAR BLAUWEISS, PSY.D., LMHC-LP

JOEL LORD, PH.D. ABPP
CHRISTINE SHOOP, PSY.D
WENDY WYNBERG, LCSW-R
JAMES TINGER, LCSW
RACHEL LEVINE, LMHC
KELLY WARRINGER, LMHC
MARGARET CAMPBELL, LMFT-LP

124 GREEN STREET
KINGSTON, NEW YORK 12401
PHONE: (845) 331-3001
FAX: (845) 335-4600
E-MAIL: GRUNBLATTPSYCH@GMAIL.COM
WWW.GRUNBLATTPSYCHOLOGY.COM

INFORMED CONSENT AND AGREEMENT FOR PSYCHOLOGICAL SERVICES

As we begin psychotherapy, we would like to inform you about the type of work we expect we will be doing together. There are many different forms of psychotherapy. We utilize a practice we call "eclectic", which draws from a variety of procedures that have been effective in helping people deal with their emotional and social life.

While benefits can be expected from this treatment, no particular outcome can be guaranteed. We will work together to establish goals for therapy. The psychotherapeutic process can sometimes bring up upsetting feelings and, on occasion, a client may feel worse before feeling better. You will need to participate in a periodic review of your progress and goals.

As your therapists, we place a high value on the confidentiality of the information you share with us. State law and professional ethics also require psychologists, social workers, and mental health counselors to maintain confidentiality and not to release information about you without your written consent. Most of the provisions explaining when the law requires disclosure were described to you in the accompanying Notice of Privacy Practices. There are a few possible exceptions to confidentiality.

1. As your therapist we are required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm.
2. If we learn information that could result in danger, injury or harm to you, to your personal property, or to others or to their property, then we have a duty to notify some other organizations, officials, or person who in our judgment can reduce that risk of danger.
3. If you are or become involved in litigation, the court may request a report, an evaluation, or your entire mental health record. If you are requested to sign a release for your psychotherapy records, you should consult your attorney.
4. If an insurance carrier or a managed care company is paying for your treatment, then your treatment records are available to them upon request and they are likely to put your treatment information into a central database that could be accessed by others.
5. We may consult with the therapists in the practice or professional colleagues about our work together. However, your name and other identifying information will not be revealed without your express consent.
6. If we are away or unavailable, and another therapist of the practice is covering, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency.
7. Please be aware that if you use email or texting that those methods are not confidential, therefore please try to limit communication via email and texting to mainly scheduling issues.

We will try to discuss each situation with you before any confidential information is disclosed and we will reveal the least amount of information necessary. **_____ - Initial**

The psychotherapy session will be 45 minutes in length. If you have a **Deductible** that has not been met and/or no insurance coverage we will require a deposit of our regular charge of **$225** per intake session and $**175** for a regular individual session. Longer sessions will be pro-rated. There will be a **charge for telephone** contacts beyond 5 minutes in length. Generally, Insurance companies do not pay for phone contacts or phone sessions, thus you are responsible for those charges. Likewise, meetings outside the office related to your treatment including travel time will be billed accordingly. Should you need financial hardship consideration please let the office know ahead of time.

All copays are due at the time of service. **_____-Initial**

If you have a minor attending therapy, you as the guardian are required to make proper payment arrangements.

_____ - Initial

You are required to give at least **48-hour notice** if an appointment must be changed or cancelled. If you give us less than 48-hour notice or no notice, you will be billed for the missed appointment. The flat fee for **a missed appointment** is **$40**. We will reschedule your appointment whenever possible. Insurance companies do not pay for broken or missed sessions.

_____ - Initial

Grunblatt Psychology and Counseling Offices, P.C. may participate in **training** clinicians who provide individual, family or couple therapy or who help run groups, or provide testing under supervision of our seasoned clinicians. This is to teach clinicians to become more experienced. Confidentiality agreements apply to everyone observing services being provided or providing services at Grunblatt Psychology and Counseling Offices, P.C.

_____ - Initial

For **Testing,** Insurance companies generally only pay for face to face contact. The time to score the tests and to write up a report will not be paid by Insurance, so you will be responsible for those charges. Usually, we request that you pay an initial retainer for testing services in the amount of $750. This retainer is based on our fee of $200 per 45 minutes for scoring or report writing. Should it take us less time, or should the Insurance Company pay for such services we will gladly reimburse you for any remaining amount.

_____ - Initial

For **Therapeutic Visitation or court ordered services,** Insurance companies generally do not pay, because they are not based on medical necessity. Our fee for therapeutic visitations is $250 per 45-minute session. This fee will be applied in increments of 5 minutes to any contact in person, on the telephone, or in writing that we make with you, your attorneys, the court, or other involved parties.

_____ - Initial

For **Mental Health Evaluations**, we charge a flat fee of $3000. This fee will be applied to time spent for testing, report write ups, contact with lawyers, courts, or other entities involved.

_____ - Initial

If we are required to **testify in court**, we charge $1250 for a half day or $2500 for a full day. A retainer of $1000 is required before services begin. An additional retainer of $1500 is required if testifying in court is required, at least three weeks prior to court performance. Please also be aware that should you request us to testify in court you wave confidentiality of the content of our sessions together. We do not guarantee any outcome of our court involvement.

_____ - Initial

We are engaged to provide **psychotherapeutic treatment**, not "expert testimony" for court. As our client you agree not to require us to provide "expert testimony" in any litigation. Should we be subpoenaed or be required by a court to participate in a deposition, give testimony, records, or other information to attorneys or Court, you agree to pay us $250 per 45 minutes.
(Please review section on **therapeutic visitation or court ordered services** for a more detailed explanation).

_____ - Initial

You are making **the choice to begin psychotherapy**. You have the right to end your treatment at any time. If you decide to leave treatment, you are encouraged to speak with us before leaving so we can end our work appropriately and we can assist you with making plans for future treatment if necessary. Missing three consecutive scheduled appointments without explanation or notification will constitute voluntary termination by you.

_____ - Initial

By signing below, you indicate that you have read and understood this agreement and give consent to treatment.

Client's Name(s):
(Printed)_____

Signature(s):_____ Date_____/_____/20_____

GRUNBLATT PSYCHOLOGY AND COUNSELING OFFICES, P.C.

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124 GREEN STREET
KINGSTON, NEW YORK 12401
PHONE: (845) 331-3001
FAX: (845) 335-4600
E-MAIL: GRUNBLATTPSYCH@GMAIL.COM
WWW.GRUNBLATTPSYCHOLOGY.COM

Authorization Form (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____

1. I authorize the Healthcare practitioner Grunblatt Psychology and Counseling Offices, P.C., 124 Green Street, Kingston, New York 12401 (the 'Practitioner') and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below to:_____
_____(name and address of person/entity to receive information)

2. I am hereby authorizing the disclosure of the following protected health information:
_____
_____(Specif
ically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.)

3. This protected health information is being used or disclosed for the following purposes: _____At the request of the individual or_____ (enter specific reason)

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

_____ _____
Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient — (If a Personal Representative state relationship to patient.)

I received a copy of this Authorization form _____ (please initial)