**HIGH PLAINS PSYCHOLOGICAL ASSESSMENT CENTER**
**Dr. Jennifer Barth**
**1920 Thomes Avenue, Suite 500**
**Cheyenne, WY 82001**
**307-640-7720**

AUTHORIZATION FOR EXCHANGE OF PROTECTED HEALTH INFORMATION

______________________________________ ___________________
Client Name Date of Birth

I, ______________________________, hereby authorize High Plains Psychological Assessment Center to exchange information with ________________________________________________.
(Name of Person/Organization)

Description of Information to be Disclosed (Client/Legal Guardian should initial each item to be disclosed):

_____ Evaluation Results/Neuropsychological Report
_____ Background/Historical Information
_____ Medical Information
_____ Psychiatric Evaluation
_____ Educational Evaluation, IEP, 504 Plan
_____ Teacher Rating Form
_____ Treatment Plan or Summary
_____ Progress in Treatment/Treatment Update
_____ Discharge/Transfer Summary
_____ Legal History
_____ Complete Record
_____ Other____________________________

Teacher's Email Address ________________________________________________________________

The purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care and guide treatment.

I understand that by signing this authorization:

- This authorization is in effect until one year from the date it was signed.
- I authorize the use or disclosure of individually identifiable health information as described above for the purpose listed.
- I understand that information shared may be in written, verbal or electronic form.
- I have the right to withdraw permission for the exchange of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily. Treatment and other services will not be affected if I do not sign this authorization.
- 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.

Signed by Patient: ________________________________________ Date: ____________________

Signed by Parent/Legal Guardian: ______________________________________________________

On Behalf of ______________________________________________________
Patient's Name