Authorization to Use and Disclose Protected Health Information

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

Printed Name: _____ Date of Birth: _____.

I authorize this person or organization: _____

To use or disclose the following information:

- □ Complete copy of treatment records, including dates of attendance, problem history, diagnoses, prognoses, level of functioning, treatment plans and recommendations, as well as progress notes and other written records related to treatment
- □ Treatment summary only (dates of attendance, diagnosis, prognosis and level of functioning)
- □ Psychological evaluations, reports, or assessment results, and dates
- □ Billing records and dates of service
- □ Other: _____

To: Thomas Kot, Ph.D.

The information will be used/ disclosed for the following purposes:

- □ Coordination of treatment with other providers
- □ Transfers/Referrals
- □ Billing/Insurance
- □ Legal
- □ Other: _____.

I understand and agree that this Authorization will be valid for one year, until_____.
I understand that after that date, no more of this information can be released unless I sign a new Authorization.

I understand that I can revoke or cancel this Authorization by sending a letter to the Dr. Kot, supplying the released information. The letter revoking this Authorization will prevent any disclosures after the date the letter is received, but cannot change the fact that some information may have already been shared before that date.

I understand that my right to receive treatment and my eligibility for benefits may not be conditioned on my agreement to sign this Authorization.

I understand that if the person or organization that receives the released information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear has been explained to me, and that I now understand all of it.

_____ _____
Signature of patient or representative Date

_____ _____
Printed name of patient or representative Relationship to patient

I, Dr. Kot, have discussed the issues above with the patient or their personal representative. My observations of their behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Thomas Kot, Ph.D. Date
(NJ#4160 and NY#15755)