MARK PRANGE, PH.D.

CLINICAL PSYCHOLOGY
CHILD AND FAMILY PSYCHOLOGY

Authorization to use and disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about
Printed name:_____ Date of Birth: _____

2. I authorize this person or organization _____
_____

3a. To use or disclose the following information:

- ☐ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness.
- ☐ Admission and discharge summaries
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.☐
- ☐ Social, family, educational, and vocational histories
- ☐ Social work assessments, occupational therapy and vocational reports and evaluations
- ☐ Progress, nursing, case or similar notes.
- ☐ Evaluations and reports of consultants.☐
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.☐
- ☐ Billing records.
- ☐ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here ☐☐ Do not release these.
- ☐ Complete copy of the medical record.
- ☐ Other: _____

3b. Dates of care included: From _____ to _____ and
From _____ to _____ and
From _____ to _____

4. To this person or organization _____

_____

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

13907 NORTH DALE MABRY HIGHWAY, SUITE 204 TAMPA, FLORIDA 33618
(813) 961-7727

6. I understand and agree that this Authorization will be valid and in effect until _____ [Enter a date or event upon which this Authorization expires.] I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy the health information described in this authorization. There may be a cost for this copy or other services. ☐ Does not apply

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

11. I understand that the professional or facility listed in number 2, above, will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. ☐ Does not apply

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

13. _____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

14. ☐ I acknowledge that I received a copy of this completed form

15. I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

_____ _____ _____
Signature of professional Printed name of professional Date