COMPLETE CHILDREN'S HEALTH, P.C.

Authorization to Disclose and Obtain Protected Health Information (Psychology)

By signing this Authorization, I authorize and permit the use and disclosure of my protected health information for the purposes and manner described in this form.

Patient Name: _____ **Date of Birth:** ___/___/___
Last First MI

I authorize _____, Complete Children's Health, phone: (402) 465-5600, fax: (402) 327-6099
(Name of Psychologist)

to DISCLOSE to and OBTAIN information from:

Name of Clinic/Organization/Provider: _____

Address: _____ **Phone:** _____ **FAX:**_____

Reason for Release: ☐ Transfer Records to New Provider; ☐ Coordination of care/ treatment planning;

☐ Legal Purposes; ☐ Other : _____

Disclose and Obtain the following Information: ☐ Entire Medical Record; ☐ Evaluation/consultation Reports

☐ Psychological / Social Information including observations and rating forms; ☐ School Records; ☐ Verbal Report;

☐ Other _____

I understand that the information to be released may include information regarding psychological or psychiatric conditions, Drug and Alcohol usage, and AIDS/HIV/sexually transmitted disease. I understand that once this information is disclosed, it may be subject to re-disclosure by recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. By signing below, I acknowledge receipt of a signed copy of this authorization.

Expiration or revocation of authorization: This authorization shall expire one year from the date of this authorization. I understand I can revoke this authorization at any time by notifying CCH in writing.

Reimbursement: Complete Children's Health, P.C. reserves the right to recover costs involved in producing the requested Health Information. You or the Party to receive disclosure, named above, may be charged $20.00 plus 50 cents per page for handling and copying this information.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Age: If the patient is 19 years of age or older, the patient must sign and date the form.

_____ _____ _____
Printed Name (Parent/Guardian if under 19 years old) Date Phone number if questions

_____ _____
Signature Relationship to patient

☐ I consent to communication via e-mail between the above parties. I have received the CCH Psychology E-mail Policy.

☐ I do NOT consent to communication via e-mail between the above parties.

For office use only:

COMPLETE CHILDREN'S HEALTH

Patient E-mail Policy

E-mail can be a preferred and requested form of communication between patients/responsible parties and providers. However, such communication create risks to your confidentiality. We want you to be aware of the risks and make an informed decision regarding these forms of communication.

Risks of using email

Transmitting patient information poses several risks and the patient/guardian should not agree to email communication without understanding and accepting these risks. The risks include, but are not limited to the following:

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail.
- Emails can introduce viruses, generally damage, or disrupt the computer.

Conditions of using email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received. However, we cannot guarantee the security of email communication. Thus patients/guardians must understand that when sending records or information via email, the following conditions apply:

- Use of the patient portal and/or fax is the preferred method of communication for patient information. Email should be used when these forms of communication are not possible.
- Emails sent or received concerning patient information may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access to the medical record/email.
- Email should not be used for medical emergencies or other time sensitive matters.
- Complete Children's Health is not liable for breaches of confidentiality caused by the patient or any third party.
- Complete Children's Health is not responsible for information loss due to technical failures associated with the patients email software or internet provider