Silicon Valley **Assessment**
NEUROPSYCHOLOGICAL ASSESSMENT, DIAGNOSIS, AND TREATMENT PLANNING

# AUTHORIZATION FOR USE or RELEASE OF PROTECTED HEALTH INFORMATION

When you complete and sign this form, health information about you will be released as you describe in the form.

Client Name: (First, M, Last): _____

Date of Birth: _____ Phone Number: _____ Social Security Number: _____

**You authorize:** (Persons/organizations providing information):

☐ HIMS AME:_____ ☐ PCP:_____

☐ HIMS Psychiatrist:_____ ☐ Psychiatrist:_____

☐ Other Providers (please list):_____

**To disclose to:**

Silicon Valley Assessment
Attn: **Maya Yutsis, PhD, ABPP-CN**
15495 Los Gatos Blvd, Ste 1
Los Gatos, CA 95032
(t) 408-827-5699; (f) (855) 557-8583

**The following information:**

☐ Background information about client's relevant medical, psychiatric, academic, and/or psychosocial history
☐ Non-certified FAA Medical Record File sent directly from your HIMS AME and/or psychiatrist.
☐ Medical or psychiatry records (*provide dates for each record of interest*): _____
☐ Other _____

**Purpose of Disclosure**

☐Provide relevant information to assist with a psychoeducational or neuropsychological evaluation at the request of the client or client's guardian/personal representative

☐ At the request of the client (this is sufficient if you are the client)

☐ Other_____

**Method of Disclosure**

** Please check box next to the preferred method of disclosure of this information

☐ Mail: Silicon Valley Assessment
Attn: **Maya Yutsis, PhD, ABPP-CN**
15495 Los Gatos Blvd, Ste 1
Los Gatos, CA 95032

☐ Fax: (855) 557-8583

☐ Verbal communication (i.e. a right to contact your provider via phone and ask about the required information)

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**Expiration**
This information will be used for the purposes of evaluation and /or ongoing treatment, and will not be disclosed without your prior written consent. This authorization will automatically expire within 90 days from the date of execution unless a different end date is specified (MM/DD/YYYY): _____

**Your Privacy Rights**

1. You may refuse to sign this authorization. Your refusal will not affect your ability to obtain services through our facility
2. Your refusal to sign this form will not affect your ability to obtain insurance payment or eligibility for benefits, if and when you seek reimbursement from your insurance carrier.
3. You have the right to revoke this authorization at any time **in writing**. You should submit such written notification to the office address: Silicon Valley Assessment, 15814 Winchester Blvd, Ste 105, Los Gatos, CA 95030. Your revocation will take effect upon receipt of your notice, EXCEPT in the case when we have already acted in reliance upon the originally signed authorization.
4. You have a right to receive a copy of this authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Client/Guardian/Personal Representative Signature Date

_____
Printed Name

_____
Relationship to client if other than self