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: Silicon Valley Assessment (Maya Yutsis, PhD, ABPP-CN/ Lauren Drag, PhD, ABPP-CN)

To disclose to: (Persons/organizations authorized to receive information) _____

The following information:

☐ Neuropsychology report by Silicon Valley Assessment from (MM/DD/YYYY): _____

☐ Background information about client's relevant medical or psychiatric history

☐ Medical or psychiatry records (*provide dates for each record of interest*): _____

☐ Other _____

Purpose of Disclosure

☐ Provide relevant information to assist with ongoing treatment/continuing care

☐ 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 (please provide your address):_____

☐ Encrypted Email (provide email address): _____

**Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

**Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us.

- Under HIPAA and Patient Privacy rights, you have the right to request the report to be sent to you via unencrypted email. If you choose unencrypted email method, please download and fill out the following form from our website: **Request for Unencrypted Communication.**

☐ Fax (provide number): _____

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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