Square One, LLC

Specialists in Child and Adolescent Development
6440 Dutchmans Parkway
Louisville, KY 40205-3338
Phone: (502) 896-2606 Fax: (502) 896-0487
meds@squareonemd.com

Email communications are password secure but not encrypted and may be subject to unauthorized redisclosure or hacking.

Authorization For Use And/Or Disclosure of Protected Health Information (PHI)

Patient Name_____ Date of Birth _____

I _____ hereby authorize and request the release of all Protected Health

Information (PHI) on my child/me:_____

To or From: *Square One, LLC* **To or From:** *facility name*_____

___ **Fax:** # _____ ___ **Phone consultation:** # _____

___ **Mail:** *address*_____ *City ST Zip*_____

including the following (*mark all that apply*):
_____ Entire Health Record (including psychotherapy notes)
_____ Health Record (without psychotherapy notes)
_____ Medical Evaluation Report _____ Psychiatric Evaluation Report _____ Psychological Evaluation Report
_____ Speech-Language Evaluation Report
_____ Billing Records
_____ Other (please list)_____

- I understand that if my protect health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be redisclosed and would no longer be protected.
- I understand that this information may include information relating to Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter to Square One, LLC at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty (180) days from the date of this form or on the following date or event _____.
- I understand that I may refuse to sign this authorization and that Square One, LLC may not condition treatment on the completion of this authorization except as indicated in 45 CRF § 164.508(b)(4).

I certify that I have read and received a copy of the authorization. This authorization supercedes any and all previous authorizations.

Signature: _____ Date _____
(Patient or Patient's Representative)

_____ Relationship to Patient _____
Printed Name of Patient's Representative given authority to act for patient.