**SQUARE ONE, LLC**
**Specialists in Child and Adolescent Development**
**6440 Dutchman Parkway**
**Louisville, KY 40205-3338**
**(502) 896 - 2606 Fax (502) 896 - 0487**
**meds@squareonemd.com**

SQUARE ONE
SPECIALISTS IN CHILD & ADOLESCENT DEVELOPMENT

## 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 ____

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 protected 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 supersedes 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

## AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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## EVALUATION REPORTS RELEASE AUTHORIZATION

Two copies of the evaluation report are available approximately four weeks after the initial evaluation is performed or two weeks after the parents-only consultation following the evaluation.

- You have the option of receiving both copies or having a copy mailed to a facility authorized by you at no charge.
- It is strongly recommended that the parent/guardian photocopy the report for additional record requests made by other facilities involved in your child's care.
- A fee of $15.00 per evaluation report shall be charged for additional copies of reports requested by parents/guardians.

I authorize Square One, LLC to disclose medical, psychological and/or speech. Language evaluation reports for the person named below:

PATIENT NAME_____ DATE OF BIRTH_____

PARENT/LEGAL GUARDIAN: _____

TO THE FOLLOWING:

1. NAME (PARENT/GUARDIAN/PATIENT): _____

   ADDRESS: _____

2. NAME (i.e., REFERRAL SOURCE, PEDIATRICIAN, ETC.):

   _____

   ADDRESS: _____

As required by Kentucky law KRS 422.317: Patients/guardians are entitled to one free copy of the medical record, "A copying fee, not to exceed one dollar ($1) per page, may be charged by the health care provider for furnishing a second copy of the patient's medical record upon request either by the patient or the patient's attorney or the patient's authorized representative."