Bonnie Connor, PhD
PSY 22446
Davis: 530.750.1700 Walnut Creek: 925.407.4774
F: 800.390.1612

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____

Date of Birth: _____

Consistent with California and Federal Law I authorize the disclosure and use of my Protected Health Information (PHI).

Bonnie Connor, Ph.D., Licensed Psychologist PSY 22446, is authorized to **communicate** (verbally or in writing) anything that has been brought up during neuropsychological evaluation or psychotherapy treatment with any person(s) or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

For the following reason(s):

- ☐ Diagnosis/Treatment
- ☐ Consultation
- ☐ Neuropsychological Evaluation
- ☐ Other: _____

This authorization shall remain valid until:_____

My Rights as a Patient:
I have a right to receive a copy of this authorization. I may revoke this consent at any time. The revocation of this authorization will be effective upon written receipt except when action has been taken in reliance on this authorization. This authorization will be placed in my flle. I understand any cancellation or modification of this authorization, to be effective, must be in writing and received by Bonnie Connor, PhD at PO Box 1216 Davis, CA 95617.

I have the right to refuse to sign this form and my health treatment or fees will not be conditioned upon whether or not I sign this authorization. Information disclosed pursuant to this authorization to a party not required to keep it confidential may be subject to re-disclosure and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This consent is in effect only for five (5) years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies form.

_____
Name (print)

_____ _____
Patient's Signature Date

_____ _____
Patient's Representative Signature Date
(Parent, Guardian, Conservator)

If signed by someone other than the patient, state your legal relationship to the patient and your authority to act on his or her behalf.

_____

Submit