Mary Galaszewski, Ph.D.
Fountain Plaza
505 S. 336th St., Suite 415
Federal Way, WA 98003

Phone: (253) 569-7698

HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize _____ to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Progress in Treatment
____ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Mary Galaszewski at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires in 90 days.

Conditions

I further understand that Dr. Mary Galaszewski will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

_____

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Psychologist Date