***Mark S. Schwartz, Ph.D****.*

Clinical Psychologist

Emeritus Staff, Mayo Clinic

**12528 Charles Cove Rd., Kensington Lakes, Jacksonville, FL 32246-7052**

Email: **DrSchwartz@MarkSSchwartzPhD.com**

Phone: **904-910-4122**

FL License: PY 4052

**PATIENT INTAKE EVALUATION FORM 07/03/15**

**PLEASE COMPLETE ALL INFORMATION. PLEASE PRINT CLEARLY**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

 (Last) (First) (MI)

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_\_

DATE OF BIRTH \_\_/ \_\_/ \_\_ EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_

PHONES: HOME ( \_\_\_)\_\_\_-\_\_\_\_\_\_\_ WORK (\_\_\_)\_\_\_-\_\_\_\_\_\_\_\_\_\_ CELL: (\_\_\_) \_\_\_-\_\_\_\_\_\_

EMPLOYED \_\_\_ YES \_\_\_ NO PLACE OF EMPLOYMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_\_

STUDENT \_\_\_ YES \_\_\_ NO WHERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DO YOU PLAN TO PAY FOR SESSIONS/CO-PAYS/CO-INSURANCE ?

 \_\_\_ CASH \_\_\_\_ CHECK \_\_\_\_ CREDIT CARD

INSURANCE ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP #: \_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_ ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_

YOU WERE REFERRED TO ME BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT - NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_ PHONE # (\_\_\_) \_\_\_\_- \_\_\_\_\_\_

**I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES AND CHARGES. I UNDERSTAND IT IS NECESSARY TO PAY FOR SERVICES WHEN PROVIDED. CANCELATIONS WITHOUT A 24 HOUR PRIOR NOTICE CAN BE RESULT IN A $100. CHARGE TO THE PATIENT.**

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_/ \_\_\_/ \_\_\_

**RESPONSIBLE PARTY INFORMATION IF OHER THAN PATIENT**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

 (Last) (First) (MI)

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_\_

HOME PHONE # ( \_\_\_) \_\_\_ - \_\_\_\_\_\_\_ WORK PHONE # ( \_\_\_) \_\_\_ - \_\_\_\_\_\_

PATIENT’S RELATIONSHIP TO RESPONSIBLE PARTY: (CIRCLE ONE): PARENT, SPOUSE, CHILD, OTHER\_\_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_/ \_\_\_/ \_\_\_

ADDITIONAL INFORMATION

AGE \_\_\_\_ GENDER: MALE \_\_\_ FEMALE \_\_\_

MARITAL STATUS: SINGLE \_\_ MARRIED \_\_ DIVORCED \_\_ SEPARATED \_\_\_ WIDOW/ER \_\_\_

EDUCATION: HS\_\_\_ VOC SCHOOL\_\_ AA\_\_ BA/BS\_\_\_ MA/MS\_\_ DOCTORATE\_\_\_ OTHER \_\_

DATE OF LAST MEDICAL EXAM: \_\_\_/\_\_\_/\_\_\_ PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY/ALL HEALTH PROBLEMS (DIAGNOSES) FOR WHICH YOU ARE CURRENTLY RECEIVING TREATMENT. ALSO INCLUDE ALL MEDICATIONS YOU ARE NOW USING.

PROBLEMS/DIAGNOSES TREATMENTS, MEDICATIONS and DOSE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEFLY DESCRIBE REASON(S) FOR SEEKING HELP AT THIS TIME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST CLOSE FAMILY MEMBERS/SIGNIFICANT OTHERS/LIFE PARTNERS

NAME AGE RELATIONSHIP OCCUPATION CITY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

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**PROBLEMS**

**Circle every item that involves any current, recent, or long term problem.**

|  |  |  |  |
| --- | --- | --- | --- |
| NERVOUSNESS or ANXIETY | FEARS OR PHOBIAS | STRESS | OVERACTIVE OR HYPER |
| LONELINESS | SHYNESS | SELF-ESTEEM | MOOD SWINGS |
| ANGER | TEMPER  | IRRITABLE | FRIENDSHIPS |
| DEPRESSION | WORRY | SUICIDE THOUGHTS OR WISHES | GUILT  |
| CRYING SPELLS | SADNESS | FAILURE FEELINGS |  |
| ATTENTION/CONCENTRATION | MEMORY | MAKING DECISIONS |  |
| RELAXATION | FINANCES | TENSION |  |
| HABITS | EDUCATION | HEALTH |  |
| SLEEP  | INSOMNIA | NIGHTMARES | TIREDNESS, LOW ENERGY, FATIGUE  |
| MARITAL | DIVORCE OR SEPARATION | SEXUAL | RELATIONSHIPS |
| EATING, OVER | WEIGHT  | FEAR OF WEIGHT GAIN | APPETITE, LOSS OF |
| THOUGHTS  | DELUSIONS | HALLUCINATIONS |  |
| RECREATIONAL DRUG USE | ALCOHOL USE | MEDICATION USE |  |
| SCHOOL | CAREER  | AMBITION | WORK |
| LEGAL  | UNHAPPINESS | PARENTING | CHILDREN |
| BOWEL | STOMACH | NAUSEA/VOMITING | CHEST |
| HEADACHES | NECK PAIN | HEALTH WORRIES | PHYSICAL APPEARANCE |
| TIME MANAGEMENT | PROCRASTINATION | PERFECTIONISM | GOALS OR PRIORITIZING |

***Mark S. Schwartz, Ph.D.***

**Consent for Treatment and Patient/Client Information**

This page and the following pages provide some basic information about psychological treatment in my office.

**Please read and sign at the bottom of the last page to indicate that you have reviewed this information.**

**Length of Treatment**

 Psychotherapy typically involves regular sessions, usually at least 45 minutes each session, but often as long as 90 minutes, and sometimes longer. Duration of treatment, thus the number of sessions, varies depending several factors such as the nature and complexity of the problem(s), your individual goals and needs, compliance with recommendations, and unforeseen events.

**Confidentiality**

 Information shared with a mental health professional is kept strictly confidential and is not disclosed without your written permission. One exception is in the event that I am unavailable, such as from an extended illness or an extended trip, and another mental health professional is caring for my patients until I return.

 Confidentiality is not guaranteed in cases of:

1. Danger to yourself or others (for example, planning to hurt others or yourself)
2. The care of others are endangered (for example, sexual or physical abuse, or neglect of a child or elderly person), or
3. When you are going to violate or has violated a major law (e.g. Patriot Act).

*[Update 09/18/13: When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state’s confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes related to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.]*

If you wish for your insurance company to pay for your visits, they will require information regarding your diagnosis, and possibly additional information such as psychological history and the treatment plan and goals of therapy. I can provide the information that is being sent to the insurance company. In compliance with Florida law mental health professionals can provide a summary letter to insurance companies instead of sending the actual reports. You have the right to review and approve any reports or letter being sent to an insurance company.

 During your treatment with Dr. Mark S. Schwartz if you ever are involved in a legal situation your signature below acknowledges that you have been informed that there will be no one sided conferences with an opposing attorney without written confirmation from you, by court order, or as required by law or Florida Regulations.

 If psychological testing is conducted during your evaluation and treatment with Dr. Mark S. Schwartz, please note that by signing below you acknowledge that raw test data will not be released to anyone other than a licensed clinical psychologist, another properly licensed and trained individual or by court order.

**Fee Policy**

Evaluations: The ordinary charge for an evaluation is $400. to $800. The typical time for an initial evaluation session is 120 minutes.

Therapy sessions: The charge for an individual or joint therapy session of 60 minutes is $180. The charge for a sessions of about 90 minutes is $270, and $360. for 2 hours. Sessions of 20-30 minutes are $100. and for $150. for 45 minutes My Psychological Testing fee is $100 to $150. per hour. Typical total testing charge is $200. to $800.

Charges for an evaluation might require a deposit at the time it is scheduled. If the evaluation is cancelled in less than 48 hours before the appointment, there could be a minimum $100.fee.

Cancellations are required at least 24 hours before your appointment by calling and leaving a voice mail if needed. Otherwise, cancellation charges will apply. These charges are typically $50. If you are late for an appointment, there is a pro-rated hourly fee. If you do not show for a scheduled appointment and did not contact me, you are obligated for a minimum fee of $100. Please be aware that insurance carriers will not cover cancellation charges.

If you have mental health insurance, you will have a receipt for each session that contains all the needed information except for a letter or reports which I will provide for you. If feasible and appropriate I will help you submit an insurance claim. Please be aware that you are responsible for co-payments which must be made at the time of each session.

Telephone consultations are $100. to $200. for 30 to 60 minutes. Preparation of records and correspondence may be billed at a pro-rated rate if substantial time [e.g. 1+ hour(s)] is required. A fee for a special letter is $200 to $800. Court testimony and deposition charges are $250. per hour, portal to portal, plus preparation time charges at my usual hourly fee.

I reserve the right to engage the services of a collection agency in the event of unpaid balances. Charges for collection efforts also are the patient’s/client’s responsibility.

**Emergencies**

 When your therapist (Mark S. Schwartz, Ph.D) is unavailable, arrangements can be made for coverage or telephone contact as necessary.

 In case of life-threatening emergencies, you need to call 911 first. You can then call me at 904-910-4122 and leave a voice message if I do not answer. I will try to respond ASAP. Going to the closest hospital emergency room is another option. By signing below you acknowledge that your call to me will be returned including on a cordless phone or a mobile phone.

There is typically no charge for brief telephone calls to my mobile phone and no charge for a life-threatening emergency. Except for appointment related matters, calls to my mobile phone for non life-threatening emergencies, please understand the need to provide a charge. An expected charge of $100. for 30 minutes and $150. for over 30 minutes up to 45 minutes, and $200. for 45 to 60 minutes.

**Accompaniment of Guardians for all Minor Children**

 All minor children much be accompanied by a parent or legal guardian at all times while at my office. Such parent or legal guardian must remain on the premises at all times whether the child is in the waiting area or in session.

 Children age 16 or older may attend therapy sessions without the accompaniment of a parent or guardian if the parent or guardian signs a release giving their permission for the child to attend therapy without them being present.

 If a legal guardian/parent is not present at the timeof a crisis/emergency for your child, then Dr. Mark S. Schwartz may obtain emergency medical care for your child at your expense.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 Signed (if applicable) Date

**Physician Contact:** It is an established fact that physical and psychological symptoms very often interact. Therefore, I strongly encourage you to obtain appropriate medical consultation unless you have had such consultation recently. In addition, psychotropic medications are often helpful for psychological disorders. When indicated, and in the opinion of Dr. Mark S. Schwartz, a referral for medical and/or psychiatric consultation can be recommended and arranged after discussion with you.

 I might ask your permission to contact your primary care physician or specialist physician regarding treatment, in order to coordinate your psychological care with your medical care.

**Freedom to Withdraw:** You have the right to end therapy at any time and are obliged only to pay for completed sessions or fees incurred by not canceling 24 hours in advance. If requested, I can provide you with names of other qualified psychotherapists.

 I appreciate you discussing your concerns, desire to, and plan to discontinue your therapy, although this is not required. I have the right to terminate outpatient care. This would only be for extenuating circumstances deemed in your best interest.

**Reminder Call or email Request:** By signing below, I formally request that I may receive reminder calls or emails for appointments. The number I prefer to be called at is ( \_\_\_) \_\_\_-\_\_\_\_. If you have voice mail or an answering machine please indicate your desire as to whether I or my staff should leave a message by circling the appropriate answer below.

 YES – Please leave a message. NO – I prefer no message be left.

 Signing below acknowledges and gives us permission to call you by mobile phone, cordless phone or a regular land line phone, or by email.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient signature Date

 By signing below, I acknowledge that I have reviewed and received a copy of the **Consent for**

**Treatment and Client Information Form**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

**Privacy Practices Statement:** By signing below, I acknowledge that I have reviewed the Privacy Practices available from Dr. Mark S Schwartz. I recognize that I have 72 hours to remove my approval to proceed with the requirements outlined in HIPPA

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

**Informed Consent:** I have read and understand the preceding statements, have had an opportunity to ask questions about them, and agree to begin treatment with Dr. Mark S. Schwartz.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

**Form date 09/19/13**

**MARK S. SCHWARTZ, PH.D.**

**SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT**

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I understand that Dr. Mark S. Schwartz uses computer-based billing, thus, my signature below serves as a signature on file. I authorize the release of any payment and medical information necessary to process my or my family member’s claim and related claims.

 SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payments directly to Dr. Mark S. Schwartz of the insurance benefits otherwise payable to me or my family member for their professional services. I understand that I am financially responsible to Dr. Mark S. Schwartz for all charges not covered by this agreement.

 SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event that my insurance company fails to meet its obligations with respect to payment of my or my family member’s claim, I give my permission to Dr. Mark S. Schwartz to send a complaint to the State Insurance Commissioner using my name as a complainant. I also understand that I will be informed, in writing, if this occurs.

 SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if I do not meet my financial obligations in regard to payments due Dr. Mark S. Schwartz the account will be turned over to a collection agency. If the account is turned over to a collection agency I understand that I am responsible for all collection charges.

 SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARK S. SCHWARTZ, PH.D.**

**CONSENT TO USE &/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTH CARE OPERATIONS**

As a condition of providing treatment to you, the provider (Dr. Mark S. Schwartz) might request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations*. [Update 09/18/13: I will also obtain an authorization from you before using or disclosing Protected Health Information (PHI) in a way not described in this document.]*

You may revoke this consent at any time my notifying the provider *in writing,* except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (“Privacy Notice”) for a more complete description of the uses and disclosures that the provider may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

The provider has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that the provider restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restrictions, the provider will honor the request and it will be binding.

*[Update 09/18/13:*

***Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket****. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.*

***Right to Be Notified if There is Breach of Your Unsecured PHI.*** *You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule); (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is low probability that your PHI has been compromised.*

I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Personal Representative of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Description of Representative’s Authority to Act on behalf of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_/ \_\_\_\_/ \_\_\_\_

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* Amended 09/18/13 for updated HIPAA Rules and updated by Mark S. Schwartz, Ph.D. 03/01/15