Aspire Psychological Services LLC
2266 S Dobson Rd. Suite 200, Mesa, AZ, 85202
Dr. Suedmeyer - suedmeyer@aspireaz.com – (602) 935-5447
Dr. Frose - frose@aspireaz.com – (602) 730-1385
www.aspirepsychservices.com

Authorization for Disclosure of Health Services Treatment Information

I, _____, whose date of birth is _____, authorize Aspire Psychological Services, LLC to disclose to and/or obtain pertinent healthcare information (see below).

Description of information to be disclosed (lease initial each item to be disclosed):

_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment

Purpose

_____ Treatment Notes
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Other

This information may be used or disclosed in connection with mental/behavioral health treatment, coaching, psychological assessment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Aspire Psychological Services, LLC in the future. 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 three years from the date of authorization of disclosure.

Conditions
I further understand that Aspire Psychological Services, LLC 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.

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Redisclosure
I understand that there is the potential that the protected health information 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 Patient / Date

_____
Signature of Parent, Guardian or Personal Representative (If Applicable) / Date

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

_____Check here if you would like to refuse to sign authorization