SID BINKS, PhD
& ASSOCIATES
FORENSIC NEUROPSYCHOLOGICAL SERVICES

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AUTHORIZATION FOR DISCLOSURE

I, _____(patient/claimant/defendant), whose date of birth is _____, authorize Dr. Sid Binks & Associates to disclose to and/or obtain from _____ _____ the following information: all treatment and diagnostic records and/or_____.

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 there is another purpose, it is specified here: _____.

Revocation

I understand I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Sid Binks & Associates at the address at the top of this form. 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 consent expires one year from the date this form is signed, or, as otherwise indicated: _____.

Conditions

I further understand that Dr. Sid Binks & Associates will not condition my treatment on whether I give my authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may result in inaccurate diagnoses and/or less than optimum treatment and/or the following consequences: _____.

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 we deem appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal Law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42.C.F.R. Part 2. Other types of information may be disclosed by the recipient of the information only in the following circumstances: _____.

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

Patient/Claimant/Defendant Signature: _____ Date: _____ Check here:____ if patient refuses to sign Authorization. Parent/Guardian/Personal Representative (circle if appropriate) Signature: _____ Date: _____

Printed Name: _____

If you are signing as a Personal Representative, please describe (Power of Attorney, Healthcare Surrogate, etc):_____

Staff Witness Signature: _____ Printed Name: _____ Date: _____