Leslie Hannon, Psy.D., LLC

Dr. Leslie Hannon, Clinical Psychologist
80 Garden Center, Suite 320
Broomfield, Colorado 80020
(720) 560-4016

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Previous Names Street Address

_____ _____
Birth Date City, State, Zip

AUTHORIZES RELEASE Of PROTECTED HEALTH INFORMATION TO:

Leslie Hannon, Psy.D.
Managing Member of Leslie Hannon, Psy.D., LLC _____
Name of Health Care Provider Name of Provider/Plan/Other

80 Garden Center, Suite 320 _____
Street Address Street Address

Broomfield, CO 80020 _____
City, State, Zip Code City, State, Zip Code

INFORMATION TO BE RELEASED MAY INCLUDE THE FOLLOWING:

____ Assessment and Diagnosis ____ Drug/Alcohol History, Assessment, Diagnosis, and Treatment
____ Treatment Plan/Progress ____ Medication Regimen
____ Discharge Summary ____ Other (Specify) _____

PURPOSE FOR NEED OF DISCLOSURE: (Check all applicable categories)

____ Assessment ____ Service Planning ____ Continuity of Care ____ Other (Specify):_____

*I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by asking Leslie Hannon, Psy.D., Managing Member of Leslie Hannon, Psy.D., LLC. Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Leslie Hannon, Psy.D., Managing Member of Leslie Hannon, Psy.D., LLC. I am aware that my withdrawal is not retroactive and therefore, will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____**OR** if left blank, six months following termination of treatment with Leslie Hannon, Psy.D., of Leslie Hannon, Psy.D., LLC.

I have had an opportunity to review and understand the content of this authorization form. By initialing below and signing this authorization, I am confirming that it accurately reflects my wishes. _____

_____ _____
Client/Parent/Guardian Signature / Date Witness Signature / Date

A copy or facsimile of this authorization is as valid as the original. Leslie Hannon, Psy.D., LLC Form 2/22/18