Karin S. Hart, Psy.D.
Clinical Psychologist in Private Practice, PSY16672
Anxiety, Trauma, EMDR, Approved Consultant in Clinical Hypnosis
30423 Canwood Street, Suite 129 Agoura Hills, CA 91301
(818) 707-4443 FAX: (818) 707-1181
Clinical Instructor, Dept. of Psychiatry and Biobehavioral Sciences
David Geffen School of Medicine, UCLA

ADOLESCENT INTAKE FORM (for parent/guardian of adolescent child)

PARENT'S NAME _____DATE _____

PARENTAL IDENTIFYING INFORMATION

Home Phone #: _____Work Phone: _____Cell:_____

Where may I leave messages? (Please check)
Home answering machine_____ Office voicemail_____ Cell phone_____

Email Address: _____

Home Address:_____City:_____Zip:_____

Parent Date of birth: _____ Place of Birth: _____ Age: _____ Sex: ____ Soc Secty. #: _____

Occupation: _____Employer: _____

Couple Status: _____ How Long: _____

Partner's Name: _____Partner's Occupation:_____

Children's Names and Ages (circle patient's name):_____

Child's Medical Doctor: _____ Last Date Child Seen by MD: _____

REFERRAL SOURCE

( ) Medical Doctor Name and Address: _____

( ) Friend (Name if you wish) _____

( ) Insurance Company Name and Address _____

( ) Other (Please specify) _____

May I contact this person to thank him/her for the referral? Yes_____ Prefer Not_____

INSURANCE INFORMATION

Using insurance? Yes _____ No _____If yes, Insurance Co. Name_____

Insurance Company Phone_____ PolicyID #_____

Insurance Company Group # _____

Karin S. Hart, Psy.D.
Clinical Psychologist
Psy 16672

CONSENT TO TREATMENT OF A MINOR

DATE_____

I, _____, give consent to Karin S. Hart, Psy.D. to provide
parent or guardian's name

psychological treatment to:

_____.
minor's name and date of birth

This includes such services as psychotherapy (i.e., individual, parent/child, family, or group treatment) and/or psychological assessment.

I allow the therapist to provide therapeutic care as is deemed advisable.

I have the right to withdraw my consent at any time.

****
****

TIME PERIOD FOR WHICH CONSENT IS AUTHORIZED
UNLESS SOONER REVOKED IN WRITING
(ONE YEAR)

FROM: TO:

_____ _____
MONTH DAY YEAR MONTH DAY YEAR

PARENT OR LEGAL GUARDIAN

_____ _____
signature, relationship to minor date

_____ _____
signature of witness date

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(818) 707-4443

Karin S. Hart, Psy.D.
Clinical Psychologist
Psy 16672

ADOLESCENT INTAKE FORM

(Parent may help complete pages 1-3)

NAME _____ DATE _____

Please answer as many of these questions as you can, as honestly as you can. This information is confidential and will not be released to anyone without your prior consent.

IDENTIFYING INFORMATION

Home Phone #: _____ Cell Phone #: _____

Home Address: _____City, State,Zip_____

Date of birth: _____ Place of Birth: _____ Age: _____ Sex: ____ Soc Secty. #: _____

How will you be arriving to your appt?_____Emergency contact:_____

Emergency Address:_____Emergency phone#_____

Relationship to you:_____

If different from the emergency information, please list the names and phone numbers of the person(s) we should contact for appointments.

_____

PERSONAL DATA

List below the people now living in the same house with you.

Name Relationship Age Education Occupation

_____

_____

_____

List below any people who you have lived with for a significant period of time.

_____

FAMILY DATA

Do you currently live with both natural parents? _____ If not, please describe circumstances and age at which you were separated from one or both parents:

Father: Name_____ Living? _____Yes _____No If yes, age____

Marital status _____ How long _____ Previous marriages _____

How long since divorce _____ Occupation _____

Current Residence _____

How often do you have contact? _____

If no, his age at death _____ Your age at his death _____

Cause of death _____

Mother: Name_____ Living? _____Yes _____No If yes, age____

Marital status _____ How long _____ Previous marriages _____

How long since divorce _____ Occupation _____

Current Residence _____

How often do you have contact? _____

If no, her age at death _____ Your age at death _____

Cause of death _____

Brothers and Sisters (not living in the same house with you):

Name	Age	Occupation	Residence (city)	How often do you have contact?

MEDICAL INFORMATION

Medical Doctor: _____ Last Date Seen by Medical Doctor: _____

Physician's Address: _____Physician's Phone: _____

Reason for visit: _____

When was the last time you had a complete physical examination? _____

Please list prior illnesses, operations, and accidents and age of occurrence.

_____

Current health (please include any chronic medical problems.)

_____

Do you have any allergies? If yes, please specify: _____

_____

Please list any medications which you currently or regularly use.

_____

FINANCIAL AND LIVING CONDITIONS

Approximate yearly family income _____

Space in home (check one) _____adequate _____crowded

Does someone other than parents have responsibility for taking care of and disciplining the children on a frequent or regular basis? Please describe:_____

DEVELOPMENTAL HISTORY

Please answer the following questions regarding your mother's pregnancy with you and your birth.

Normal pregnancy? _____yes _____no If mother was ill during pregnancy, state illness, month of pregnancy, type of treatment received, and how long condition lasted.

_____

EDUCATION

Highest grade completed in school: _____ Grade attending now:_____

Name of school: _____

Did you skip any grades? _____Yes _____No If yes, which grade(s)? _____

Did you repeat any grades: _____Yes _____No If yes, which grade(s)? _____

Age entered first grade _____ Number of times you have changed schools _____

Best grades in: _____

Worst grades in: _____

Special abilities: _____

Special difficulties: _____

Conduct and attitude in school: _____

PERSONALITY AND INTERESTS

Your interests and hobbies: _____

How do you spend free time? _____

How would you describe your personality? _____

What kind of things, persons, situations, or activities make you happy? _____

_____

What kinds of things, persons, situations, or activities make you upset, uncomfortable, tense, or depressed?

_____

What are you likely to do when upset, uncomfortable, tense, or depressed? _____

_____

How is love expressed in your family? _____

How is conflict expressed in your family? _____

PRESENT DIFFICULTIES

Please describe your present difficulties:

Problem	When was problem first noticed?	By whom

_____

_____

In terms of reward and punishment, what has been tried to correct each problem (e.g., loss of privileges, spanking, candy, toys)? How did each one of these strategies work?

_____

_____

Which of these problems are you most concerned about? _____

What prompted you to seek help at this time? _____

Have you previously sought psychiatric or psychological help for this or any other problem? If yes, please explain: _____

_____

Have you ever been hospitalized for psychological problems? If yes, please explain and give dates:

_____

_____

Have you ever taken prescribed medication or psychological problems? If yes, please give name(s) of medication and approximate dates of use: _____

_____

Have you or members of your family experienced physical, sexual, or emotional abuse? (If yes, please explain): _____

_____

Have you or members of your family experienced an important loss such as the death of a family member, a pet, or a friend? (If yes, please explain): _____

_____

Have you had any upsetting experiences that have not been already mentioned? (If yes, please explain):

_____

Relationship with parents (describe briefly): _____

_____

Psychological problems evident in parents and/or siblings? _____

_____

Physical, sexual, or emotional abuse? If yes, describe briefly: _____

_____

Briefly describe how often and what types of alcohol and drugs have been taken by your family members during your lifetime? _____

_____

Briefly describe how often and what types of alcohol and drugs are taken in the present time by your family: _____

_____

How often do you currently drink alcohol and/or take drugs? _____

_____

PRESENT DIFFICULTIES

Please circle any of the following that apply:

Headaches	Dizziness	Fainting spells
I don't get along with mother	Stomach trouble	I don't get along with father
Bowel disturbances	Tired all the time	No appetite
Angry a lot	Unable to get along	Can't sleep at night

	with siblings	
Nightmares	Withdrawn	Aggressive
Depressed	Suicidal ideas	Takes drugs
Unable to relax	Sexual problems	Allergies
Bed-wetting	Over-ambitious	Shy with people
Can’t make friends	Inferiority feelings	I sleep too much
Fearful	Memory problems	Home conditions bad
Too active	Lonely	Nervous
Gets bullied around	Often sick	Unable to have a good time
Concentration difficulties	School problems	

Please list any additional problems or difficulties here: _____

Have you ever been given any psychological tests?_____ If yes, which ones, if known

_____When _____Where _____

Please list any other information you think might be of assistance in understanding and helping:

_____

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URL: www.drkarinhart.com

INFORMED CONSENT FOR TREATMENT
OFFICE POLICIES AND PROCEDURES

WELCOME TO MY OFFICE. As a licensed psychologist, I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may affect you. However, many of these policies will be unrelated to our work together.

PATIENT'S RIGHTS. Our relationship is strictly voluntary and you may leave the psychotherapy relationship any time you wish. You [the patient] authorize and request that I, the psychologist, provide psychological assessment, therapy, interventions and/or diagnostic procedures that now or during the course of treatment are advisable. The frequency and type of work we do together will be decided between therapist and patient.

It is understood that there is an expectation that the patient will benefit from this assessment and/or interventions but there is no guarantee that this will occur. It is understood that maximum benefit will occur with consistent attendance and that at times the patient may feel conflicted about therapy as the process can sometimes be uncomfortable.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:
When there is a reasonable suspicion of abuse to a child, dependent or elder adult.
When there is a reasonable suspicion of knowingly downloading, streaming and accessing through electronic or digital media, materials of a child engaged in an act of obscene sexual conduct.
When the client or credible third person communicates a serious threat of bodily injury to others.
When the therapist has a reasonable belief that the client may be a danger to him or herself, others or property of others. Threats communicated to family members that are then communicated to me may give rise to the duty to warn.
Brief written records are kept regarding your treatment goals and progress. Certain situations may arise where the records are subpoenaed by a judge, and I may be compelled to surrender them. This may occur when you become involved in a legal situation in which your psychological state is an issue.
If you are under the age of 18, your parents or legal guardian(s) have the right to be informed of your psychological condition, progress and treatment.

When disclosure is otherwise required by law.

I receive regular professional consultation. In such cases, neither your name or any identifying information about you is revealed.

EMERGENCY PROCEDURES:
If you have a life threatening emergency please call 911. I am not able to provide 24 hour availability. I usually return calls within 24 hours or the next business day. If you need to contact me between sessions, please leave a message at (818) 707-4443 and your call will be returned. If an urgent situation arises, follow the instructions in the voice mail and I will contact you as quickly as possible. Please do this for truly urgent situations. If you need help immediately, call 911. When I am out of town or otherwise unavailable, a qualified professional will cover for me by being available for urgent needs that cannot wait until my return.

PAYMENT: Payment is due at the beginning of each session unless other arrangements are made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. My fee is based on a 45 minute session unless otherwise stipulated. I reserve the right to periodically adjust this fee. I will give you prior notice of fee increases.

In addition to my fee for sessions, I charge for other professional services. For report writing, lengthy telephone conversations, preparation of records or time spent providing any other service requested by patients, a charge will be assessed at a prorated session fee rate. If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $200 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. My testimony will not include any forensic opinions.

SHARING OF INFORMATION
If you have been referred by an agency, HMO, PPO, or other third party payer, I am usually required to furnish information to that agency. Your signed agreement with them gives them permission to request information. Your signature below indicates the following:

- I authorize release of required information in order to process claims with my payer. You are authorizing payment of psychological/medical health and hospital benefits to me for the professional services rendered.

- I authorize Dr. Hart and/or her billing supervisor to furnish information to my third party payer concerning my psychological treatment in order to process payments and benefit utilization.

- I authorize communication between Dr. Hart and her bookkeeping/office staff as well as other healthcare practitioners for professional consultation pursuant to coordination of my care. I authorize my behavioral healthcare professional to communicate the above mentioned confidential information in person, by telephone, by written material, or by facsimile. Dr. Hart cannot be held responsible for maintaining confidentiality once information has left her office. I release the source of these records from any liability arising from their release.

- Clinical information may be sent in a written report to your Primary Care Physician (PCP). This communication is important for the coordination of your care. Dr. Hart will first obtain your signature approving this written communication.

- I understand that my records may be reviewed by representatives of my payer to assure compliance with Quality of Care standards.

- I understand that I have the right to access my Private Health Information (PHI) in mental health records that are used to make decisions about my treatment as long as the PHI is maintained in the record. I understand that this request may be denied, but in some cases this decision may be reviewed.

- I understand that I have the right to formally appeal decisions regarding authorized treatment services by contacting my health plan. I further understand that I have the right to submit a complaint or grievance to my Practitioner regarding any aspect of my care or I may submit complaints to my health plan or to the Secretary of the U.S. Dept. of Health and Human Services. I understand that I risk nothing in exercising these rights.

TERMINATION OF THERAPY SERVICES:

I may terminate therapy services at my discretion. I may consider termination if:

. I do not believe that I can provide you with effective treatment
. Your needs are outside the scope of my experience or training
. You desire to terminate treatment or we mutually agree it is time to terminate treatment
. You fail to comply with my treatment recommendations
. A conflict of interest develops
. You fail to pay my fee on a timely basis
. You or I believe it is in your best interest

ADDRESS CHANGES:

Please advise me if you change your address, telephone number, place of employment or insurance coverage or companies.

A photocopy of this release is to be considered as valid as the original. This authorization if subject to a modification/revocation by either party at any time except to the extent that action has been taken in reliance hereon. If these policies and procedures are to be revised I will receive notice by mail.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT

I have read, understood, and agreed to the conditions stated above.

_____ _____

Client/Parent/Guardian Name Client/Parent/Guardian Signature Date

Karin S. Hart, Psy.D.
Clinical Psychologist
Psy 16672

Financial Agreement

Please read the following and sign below.

All professional services provided are charged to the patient unless there is an agreement with a third party payer. Patients are personally responsible for payments of co-payments, co-insurance amounts, deductibles, and percentage shares of charges for services rendered, and/or all charges incurred if insurance coverage terminates or changes during the course of treatment. The payment is due at the time of the session. All co-payments must be paid at the time of service. If your check is returned, there will be a $15.00 fee charged, a cancellation fee, plus the bank charges will be added to your account.

IF YOU ARE QUOTED THE INCORRECT CO-PAYMENT AMOUNT, YOU WILL BE REQUIRED TO MAKE UP ANY DIFFERENCE AS INDICATED BY YOUR HEALTH PLAN OR THIRD PARTY PAYOR EXPLANATION OF BENEFITS.

Appoinments and Cancellation: Appointments are scheduled and rearranged by telephone. Since the scheduling of an appointment involves the reservation of time specifically for you a MINIMUM OF 24 HOURS NOTICE is required for rescheduling or cancellation of an appointment. The full fee will be charged without such notification.
This policy is necessary because a professional time commitment is set aside and held exclusively for you. If I receive 24 hours notice, you will not be charged. I do not accept, review or respond to emails or texts from you or someone on your behalf.

Delinquent Accounts: If your account becomes delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent we may utilize the services of an outside collection agency, retain an attorney, or utilize small claims court action. In the event collection or legal action should become necessary to collect any unpaid balance due to services rendered to me and my family, I agree to pay collection, attorney, and court costs.

A copy of this assignment is as valid as the original.

_____ _____

Patient/Responsible Party **Signature Date**

_____

Patient's Printed Name

Karin S. Hart, Psy.D.
30423 Canwood Street, Suite 129
Agoura Hills, CA 91301

Telephone: 818 707-4443
Fax: 818 707-1181
Email: Talk2DrH@Gmail.com
URL: www.drkarinhart.com

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: September 20, 2013.

I understand that your health/mental health information is personal and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.

Individually identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "Protected Health Information (PHI)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

I reserve the right to change this notice and to make changes in my privacy practices. Any changes will be effective for all PHI that I maintain, including health/mental health information created or received before I made the changes. I will post a copy of the current notice in my reception area and on my website (if applicable). You may also request a current copy of this notice from me. For more information about my privacy practices, please contact me at the number listed at the end of this notice.

How I May Use and Disclose Health/Mental Health Information About You:

The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI For Which No Signed Authorization is Required:

- **For Treatment:** I may use/disclose your PHI (or your child) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

- **For Payment:** I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For

example, I may send your PHI to your insurance company to get paid for the services we provided to you or to determine eligibility for coverage.

- **For Health Care Operations:** I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

- **Appointment Reminders or Changes in Appointments:** I may use/disclose your (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a change in your appointment. For example, if I am ill, I may have someone in my office contact you to notify you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

- **When Disclosure is Required by state, federal or local law; judicial or administrative proceedings; or law enforcement:** I may use/disclose your (or your child's) PHI when a law requires that I report information about suspected child, elder or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

- **To Avoid Harm:** I may use or disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.

- **Law Enforcement Officials:** I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or grand jury or administrative subpoena.

- **For Health Oversight Activities:** I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

- **Specialized Government Functions:** I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

- **Disclosure to Relatives, Close Friends and Other Caregivers**: I may use or disclose your PHI to a family member, other relative, a close personal friend or any other person that you indicate is involved in your care or the payment of your care unless you object in whole or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, I may exercise my professional judgment to determine whether a disclosure is in your best interests. If I disclose PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

- **Workers' Compensation**: I may disclose your PHI as authorized by and to the extent necessary to comply with California law relating to workers' compensation or other similar programs.

- **As required by law:** I may use and disclose your (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI For Which a Signed Authorization is Required: For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

- **Psychotherapy Notes**: I keep "psychotherapy notes" as that term is defined in 45 CFR Section **164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is**:

    1. For my use in treating you.
    2. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    3. For my use in defending myself in legal proceedings instituted by you.
    4. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    5. Required by law, and the use or disclosure is limited to the requirements of such law.
    6. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    7. Required by a coroner who is performing duties authorized by law.
    8. Required to help avert a serious threat to the health and safety of others.

- **Marketing Purposes:** I will not use or disclose your PHI for marketing purposes**.**
- **Sale of PHI:** I will not sell your PHI in the regular course of my business**.**
- **Fundraising Purposes:** I will not contact you for fundraising purposes**.**

<u>Your Rights Regarding Your (or Your Child's) PHI</u>:

You have the following rights regarding PHI I maintain about you (or your child):

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for other reasons pertaining to California or federal law. I will respond to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

If Your Request to Inspect and Copy is Denied, you may have the right to request to have this denial reviewed by a licensed health care professional who I designate to act as a reviewing official. The reviewing official will be an individual who did not participate in my determination to deny access. I will provide or deny access in accordance with the determination of the reviewing official.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your request, I will put it into writing and comply with it except in emergency situations. I cannot agree to limit uses and/or disclosures that are required by law.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/ mental health information, you may request, in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that: was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to Request Restrictions for Out-Of-Pocket Expenses Paid for in Full: You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (your child's) PHI has been disclosed. This applies to disclosures other than those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six [6] years and may not include dates before April 14, 2003). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have the right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints:

If you think that your privacy rights have been violated you may contact me and file a complaint with me, as the Privacy Officer for my practice. My address and phone number are listed at the top of this form. You may also file a complaint with the Secretary of the U.S. Department of Health and Human by sending a letter to the following address:

Office of Civil Rights
90 7th Street, Suite 4-100
San Francisco, California 94103
(415) 437-8310
(415) 437-8329 fax

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Client's Name: _____ Date of Birth: _____

Parent/Guardian's Name (if client is a minor): _____

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Client (Parent or Guardian if Client is a minor)

Date

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Clinical Instructor, Dept. of Psychiatry and Biobehavioral Sciences
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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (HIPAA and California Law)

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name: _____Date of Birth: _____

My therapist, KARIN HART, PSY.D., is authorized to (*check all that apply*):

- ☐ Release or disclose records and/or information to
- ☐ Obtain or use records and/or information from
- ☐ Mutually discuss and exchange records and/or information

This Information should only be released to: (Provide name or function of person(s) or organizations to whom the information is to be released).

_____

(Name of Person or Organization)

Specific Information to be Released/Obtained:

☐ All health/mental health information including diagnosis and treatment received.

***Please specify if any information is to be excluded*:**

_____

This disclosure of information authorized by Client is required for the following purpose:_____.

This authorization shall become effective immediately and expire in one year.
A photocopy or facsimile of this form is to be considered as valid as the original.
Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to _____(therapist). Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Signature of Client/Parent/Guardian: **Date:**

_____ _____

Your Relationship to the Client: _____

To Revoke Authorization Only:

Authorization Revoked: ___/___/___

_____

Signature of Client/Parent/Guardian