Valerie Yeo, PsyD, LLC
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, _____[client's name] _____ [client's date of birth], give permission to Valerie Yeo, Psy.D., 2029 SE Jefferson Street, Milwaukie, OR 97222, to **(initial by all that apply)**:

_____ disclose/send my specific health information to the person(s) named below:
_____ exchange my specific health information to the person(s) named below:
_____ receive my specific health information from the person(s) named below:

_____

_____
[Name(s), address & phone number of entity to receive information]

Information to be disclosed **(initial by all that apply):**

_____Mental health treatment summary
_____Mental health session notes
_____Other (specify): _____
_____ Billing records
_____Psychological evaluation reports

This protected health information is being used or disclosed for the following purposes **(initial by all that apply)**:

_____ Continuation of mental health care
_____ Coordination with medical providers
_____ Legal Issues (specify): _____
_____ Coordination with education services
_____ Completion of evaluation
_____ Other (specify): _____

Unless revoked, this authorization expires in **(initial by all that apply)**:

_____ One year
_____ Other (indicate expiration date or event): _____
_____ On termination of mental health treatment

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization at any time. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking this authorization to: Valerie Yeo, Psy.D. at 2029 SE Jefferson, Milwaukie, OR 97222.

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

_____ _____
Signature of Client Date Signature of Witness Date

_____ _____
Printed Name of Participant (or Personal Representative) Description of Personal Representative's Authority