Tiffany Griffiths, Psy.D. & Associates, Inc.

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Authorization to use/disclose and/or obtain protected health information

I, _____, am completing this form to allow the use/disclosure of protected health information about _____.

Patient DOB:_____

I authorize Tiffany Griffiths, Psy.D. & Associates, Inc. to use/disclose and/or to obtain the following information:

- ☐ Status as a patient and dates seen.
- ☐ Psychological evaluation(s), which can include psychosocial history, symptoms, behavioral observations, diagnosis, results of testing, prognosis, and recommendations.
- ☐ Mental status exam, assessment, diagnosis, prognosis and recommendations for a third-party (i.e., for disability determination, court-ordered therapy, child-custody, coordination of care, etc.)
- ☐ Billing records
- ☐ Raw test data
- ☐ Session notes
- ☐ Treatment plan for third-party payor, which will include all or part of the following: dates seen, diagnosis, symptoms, treatment goals, progress, prognosis, and recommendations.
- ☐ Psychosocial history
- ☐ Other _____

To/from this person or organization _____
on this date, _____, until _____.

The dates of care include from _____ until _____.

_____ _____
Signature of client or his/her legal representative Relationship to client

_____
Printed Name of client or legal representative