NAME:

HopeCentral
Pediatrics and Behavioral Health
for Seattle's Rainier Valley

AUTHORIZATION FOR PSYCHOLOGICAL SERVICES

HopeCentral offers psychological services, including autism diagnostic evaluations, executive functioning evaluations, and therapy. These services are delivered by a treatment team, which may include clinical psychologists, pediatricians, nurses, and/or medical assistants.

I hereby authorize the HopeCentral treatment team to evaluate, treat and/or provide consultation to the above-named person. I will be involved in the development of my or my child's treatment plan and have been informed about the kinds of services being offered to me and my family (e.g., evaluation, individual therapy, family therapy, support groups, etc.).

I understand that the information about my or my child's care at HopeCentral will be handled in a confidential manner. I understand that clinical records may need to be submitted to Molina Healthcare, the Washington Health Care Authority, or other health insurance entities for billing purposes. I understand that clinical record reviews may be conducted periodically for the purposes of program evaluation and research. These reviews are typically conducted by HopeCentral administrators or representatives of evaluation organizations who agree to maintain the confidentiality of client records.

I understand that HopeCentral is authorized by law to release information in certain instances without client consent. Information can be released without consent if your clinician thinks you are in danger of harming yourself or someone else. As a mandated reported, a clinician must release information to the proper authorities when there is reason to suspect a child or vulnerable adult is being abused. Additionally, information must be released as directed under court order.

I acknowledge that I have received a copy of the following:

1. This Authorization for Psychological Services statement.
2. The Notice of Privacy Practices, which contains information on client privacy rights, HopeCentral responsibilities to protect your confidentiality, and the client complaint procedure.
3. HopeCentral Services Guide

By signing my name below, I certify that I have read or listened to and understand the above information.

PATIENT SIGNATURE:	**DATE:**	**GUARDIAN/PARENT SIGNATURE:**	**DATE:**
PSYCHOLOGIST SIGNATURE:	**DATE:**	**RELATIONSHIP TO CLIENT:**	