Pathways Neuropsychology Associates | Health & Rehabilitation Services

Jay B. Gordon, Ph.D.
Licensed Psychologist #37590

PATIENT CONSENT FORM

Name: _____

Address: _____

Phone:_____Date of Birth:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. I authorize Pathways Neuropsychology Associates to use and disclose my protected health information to the following:

   Physicians:_____

   Attorney:_____

   Other:_____

2. This authorization for release of information covers a period of healthcare from:

   _____ to _____ *OR* _____ all past, present and future periods.

3. Extent of Authorization:

   _____ I authorize the release of my complete records.

   _____ I authorize the release of my complete records with the EXCEPTION of the following:

   _____Mental Health Records ____Communicable Diseases

   _____Alcohol/Drug Abuse Treatment ____Demographic Information

4. This medical information may be used, by the person I authorize, for medical treatment or consultation, billing or claims payment, or other purposes I direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time and this will expire when treatment ends. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if it was obtained as a condition of insurance coverage, as the insurer has the legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility of benefits will not be conditioned on whether I sign this agreement.

7. I understand that the information used to pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal and state law. I understand that my records are protected under HIPAA State Confidentiality Regulations and cannot be disclosed without my written consent or otherwise provided for in the regulations.

If patient is a minor (under 17) both parents or guardians are required to sign this release. If minor is 14-17 years of age, their signature is also required.

X_____ X_____

Patient Signature Parent/Guardian Signature

CONSENT FOR RECORDING VISITS-AUDIO

Purpose and Functionality:

iQ is a Scribe tool that uses artificial intelligence to summarize clinical documentation. iQ works by listening to the conversation during your appointment and then summarizing the session into clinical note suggestions to assist your clinician in reviewing and documenting your health record. iQ does not make any decisions regarding consumer care nor does it interact directly with you.

Benefits for Consumers:

iQ benefits both the clinician and consumers by improving the accuracy of clinical documentation, reducing documentation interruptions during appointments, and allowing the clinician to focus on the consumer.

Privacy and Security:

Privacy and Security is a top priority. iQ complies with HIPAA and the Assistant Secretary of Technology Policy/ Office of the National Coordinator regulations for Predictive Decision Support Interventions. iQ is an AI Scribe tool that is available as part of electronic health record and is not a separate tool or system limiting the risk of data exposure. iQ session audio capture and transcripts are deleted following the session. No consumer data is used to train the AI system without additional consumer consent.

X_____ X_____

Patient Signature Legal Representative

PATIENT BILL OF RIGHTS

As your right upon reading and signing this form, it is understood that you have access to all privacy practices and your Patient Bill of Rights with Pathways Neuropsychology Associates. You may access the Patient Bill of Rights at length, anytime, on our official website https://www.pathwaysneuropsychology.com/.

X_____ X_____

Patient Signature Parent/Legal Guardian Signature

HIPAA COMPLIANCE PATIENT CONSENT FORM

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

_____

By signing below, I certify that I have read and understand the above statements regarding release of protected health information, the AI recording of my visits, my patient rights, and my HIPAA rights. I also certify that to the best of my knowledge, all information I entered on these forms is true and correct.

X_____ _____ X_____ _____

Patient Signature Date Parent/Legal Guardian Signature Date

X_____ _____ X _____ _____

Legal Representative Signature Date Parent/Legal Guardian Signature Date