Authorization to Use and Disclose Protected Health Information (HIPAA)

Kenyon P. Jordan, Ph.D., ABPP
Police Psychologist
Ph: 303 / 986 – 0026
Fax: 303 / 953 - 3162
KJ@ColoradoAssessment.com

Print your full name: _____ DOB: ____ / ___ / ____

I authorize Kenyon P. Jordan, Ph.D. to use and disclose his findings and opinions concerning my past, present or future physical or mental health or condition, as well as his conclusions, opinions, and recommendations as to my psychological fitness for duty to my employer (or requesting entity) for the purposes of determining my ability to safely and effectively perform my essential work functions. *This authorization does not authorize any of my prior or current healthcare providers to disclose personal health care records to Dr. Jordan or my employer without separate and specific written authorization, except as permitted by law*.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information may be disclosed if I place my initials in the applicable space next to the type of information.

____ Mental health information [You must initial this item in order for the examination to be conducted.]
____ Drug/alcohol diagnosis, treatment, or referral information [You must initial this item in order for the examination to be conducted.]

I understand that Dr. Jordan will make a good-faith effort to restrict the disclosure of private information to the minimum necessary to satisfy the purpose of the examination and to support his findings, conclusions, and recommendations. Consistent with the provision of state and federal law, I understand that my employer (or requesting entity) will be advised to maintain any of Dr. Jordan's written reports in a confidential medical file separate from other personnel information, and that the information should be made available only to persons who have a bona fide need to know.

I expressly acknowledge that Dr. Jordan has no control over how the requesting entity uses a report once it is received. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. I expressly release Dr. Jordan from any liability for that disclosure. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

Signature

You do not need to sign this authorization. However, your refusal will mean that the required psychological evaluation will not take place. This fact may have implications for your continued employment or candidacy, but this is a determination that will be made by your employer. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, send written notice including your full name (printed), DOB, address and signature to:
Kenyon P. Jordan, Ph.D.
7700 E. Arapahoe Road, Ste 240
Centennial, Co, 80112

I have read this authorization and I understand it. Unless revoked, this authorization expires 180 days from the date below.

_____ _____
Signature Date

* Be sure to initial the 2 blanks as indicated.