Weinstein & Associates, Inc.
Authorization Forms for the treatment of Workers Injured in Ohio

There are four (4) Authorization Forms. Please sign each, below.

Authorization Form 1 - GENERAL RECORD

When completed and signed by me, this form authorizes Weinstein & Associates, Inc. and my mental health provider to release protected information from my clinical record to the persons designated in this document. I understand that treatment, payment, enrollment, or eligibility may not be conditioned on receipt of authorization.

I authorize my mental health provider and/or his or her administrative and clinical staff to release my General Clinical Record, EXCEPT PSYCHOTHERAPY NOTES. This release includes psychological reports, treatment summaries, billing information, letters to my attorney, and any other information in my record except psychotherapy notes.

This information should only be released to my attorney; other therapists within the Weinstein & Associates, Inc. practice; the Bureau of Worker's Compensation; the Industrial Commission of Ohio; my employer at the time of my injury; the attorney or Third Party Administrator working on behalf of my employer at the time of my injury; all Managed Care Organizations involved in my Worker's Compensation claim; and the Attorney General for the State of Ohio.

I ask that my mental health provider release this information at my request, for review and quality control purposes, as well as to facilitate the management of my Worker's Compensation claim.

This authorization shall remain in effect until 3 (three) years after my Workers' Compensation claim expires or until I present a written request to cancel this release to: Weinstein & Associates, Inc. main office address at 25700 Science Park Drive, #200, Beachwood, OH 44122. However, my revocation will not be effective to the extent that Weinstein & Associates, Inc. has already taken action in reliance on this authorization, (such as having already released some information).

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

Signature (1) for General Record Authorization

_____ _____

Client Signature Date

Authorization Form 2 - PSYCHOTHERAPY NOTES

When completed and signed by me, this form authorizes Weinstein & Associates, Inc. and my mental health provider to release protected psychotherapy notes to the persons designated in this document. I understand that treatment, payment, enrollment, or eligibility may not be conditioned on receipt of authorization.

I authorize my mental health provider and/or his or her administrative and clinical staff to release my psychotherapy notes.

This information should only be released to my attorney; other therapists within the Weinstein & Associates, Inc. practice; the Bureau of Worker's Compensation; the Industrial Commission of Ohio; my employer at the time of my injury; the attorney or Third Party Administrator working on behalf of my employer at the time of my injury; and the Attorney General for the State of Ohio.

I ask that my mental health provider release this information at my request, for review and quality control purposes, as well as to facilitate the management of my Worker's Compensation claim.

This authorization shall remain in effect until 3 (three) years after my Workers' Compensation claim expires or until I present a written request to cancel this release to: Weinstein & Associates, Inc. main office address at 25700 Science Park Drive, #200, Beachwood, OH 44122. However, my revocation will not be effective to the extent that Weinstein & Associates, Inc. has already taken action in reliance on this authorization, (such as having already released some information).

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.
Signature (2) for Psychotherapy Notes Authorization

_____ _____

Client Signature Date

Authorization Form 3 - ACKNOWLEDGMENT OF INFORMED CONSENT TO TREATMENT

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist I will be seeing at Weinstein & Associates, Inc. to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company, third party payer, to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through a therapist at the practice at any time. I also understand that there are no guarantees that treatment will be successful.

I understand and agree that I will make every effort to provide 24-hour notice when I need to cancel and reschedule an appointment. I am aware that my therapist and administrative staff, from the practice, will remind me of the importance of attending and participating in my therapy and will make every effort to provide our clinical availability. If it comes to pass that I am consistently late cancelling and/or no showing and/or not being available for my previously agreed upon and scheduled appointment time(s), I understand that my file may be closed and my treatment transferred outside the practice.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor) I also acknowledge that I received and/or offered a copy of the Notice of Privacy Practices for Weinstein & Associates, Inc.
Signature (3) for Acknowledgment of Informed Consent to Treatment

_____ _____

Client Signature Date

Authorization Form 4 - ELECTRONIC SERVICE DELIVERY INFORMED CONSENT (Telemedicine)

Acknowledgment of Informed Consent to Treatment via Electronic Service Delivery Means
You voluntarily agree to receive mental health assessment, care, treatment, or services and authorize your therapist to provide such care, treatment or services as are considered necessary and advisable via electronic service delivery means.

By signing this Electronic Service Delivery Informed Consent, you, the undersigned client, acknowledge that you have both read and understood all the terms and information contained herein and you agree to be bound by the provisions in this agreement. Ample opportunity has been offered to you to ask questions and seek clarification of anything unclear to you. If a minor is the client, you are signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)
You also acknowledge that you have received a copy of the regular Informed Consent and Notice of Privacy Practices for Weinstein & Associates, Inc.

Signature (4) for Acknowledgment of Electronic Service Delivery

_____ _____
Client Signature Date