the Happy Mind Company

CHILD'S NAME_____

PARENT'S NAME_____

Dear Teacher/Counselor,

We are currently evaluating one of your students for concerns regarding ADHD. In order to complete this evaluation we are asking you to complete the following questionnaire and rating scale. Each teacher should complete a separate questionnaire and survey. Once completed please return the form to the parent in a sealed confidential envelope as soon as possible so it can be returned to us.

In addition to the questionnaire and survey, it would be helpful to receive copies of any evaluations done at the school. These may include achievement tests or educational assessments, IEP reports, 504 plans, or school psychologist reports.

A signed Authorization for Disclosure of Protected Health Information by the parent/guardian is also enclosed.

Thank you for your assistance and cooperation in the completion of these forms. Please call if you have any questions regarding the enclosed material.

Sincerely,

Alyssa Adams MD

the Happy Mind Company

Please rate the child's ability in the following for his/her grade level:

	Failing	Below Average	Average	Above Average	Superior
Reading					
Arithmetic					
Spelling					
Handwriting					
Written Expression					
Overall academic achievement					
Social Interactions					

PLEASE DESCRIBE THIS CHILD'S STRENGTHS AND DIFFICULTIES AS YOU SEE THEM.

PLEASE LIST ANY SPECIFIC QUESTIONS AND/OR AREAS IN WHICH YOU WOULD LIKE TO HELP THIS CHILD.

ANY ADDITIONAL COMMENTS.

the Happy Mind Company

7601 Conroy Windermere Rd.
Suite 203
Orlando, FL 32835

Telephone: 407-704-1461
Fax: 407-704-1501
www.happymindcompany.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company **to Receive** PHI

_____

_____

_____

Name and Address of Individual/Facility **to Disclose** PHI

_____

_____

_____

Information authorized for use or disclosure, or to be obtained ***(Please circle items that should be disclosed)***:

History & Physical Discharge Summary Operative Report ER Record Consultation Lab reports

Progress Notes **X**-ray reports Other _____

Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only ***(Please circle appropriate item(s) below)***:

Insurance Continued treatment Legal At the request of the patient or patient's representative

Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be eighteen (18) months from date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.