

EVALUATION CENTER FOR LEARNING

Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name _____

Date of Birth _____

HIPAA ACKNOWLEDGEMENT

This form serves as acknowledgement that you have been informed of your rights under The Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, a copy of which has been given to you, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of this session. Your signature below serves as acknowledgement that you have received a copy of the HIPAA Notice Form (included in a separate document) described above.

Signature of Parent, Guardian, or Patients (≥ 18 years old)

Date

EVALUATION CENTER FOR LEARNING

Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name: _____ Date of Birth: _____

COMMUNICATION POLICIES

Please sign the below if you would like Dr. Edidin to email you the final report in an encrypted format. There is always some risk involved in electronic communication. Your signature indicates that you understand these risks and agree to assume the risks involved in electronic communications.

Signature of Parent or Guardian (if under 18 years old) or
Patients over 18 years old

Date

Printed Name of Parent or Guardian

Relationship to Patient

EVALUATION CENTER FOR LEARNING

Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name _____

Date of Birth _____

CONSENT FOR RELEASE OF INFORMATION TO PEDIATRICIAN

To provide effective care, it can be helpful to communicate with pediatricians about their observations and concerns. Please indicate below if Dr. Edidin may communicate with any of the following individuals or organizations.

Pediatrician's Name: _____

Pediatrician's Address: _____

Pediatrician's Phone Number _____ Pediatrician's Email Address _____

I authorize Dr. Edidin to (please check all that apply):

- Collect information from my child's pediatrician
- Disclose information to my child's pediatrician
- Send the final report to my child's pediatrician

Information to be collected and/or disclosed:

I understand that my decision to sign this form is entirely voluntary and I may refuse to sign this form. I have the right to inspect the report to be disclosed. If I do not sign this form, the information will not be disclosed other than by court order or as requested by law. I understand that I may revoke this consent in writing at any time. Any such revocation will have no effect on disclosures made prior to the date the revocation is received

Signature of Parent, Guardian, or Patients (≥18 years old)

Date

Printed Name of Parent, Guardian, or Patients (≥18 years old)

Relationship to Patient

EVALUATION CENTER FOR LEARNING

Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name _____

Date of Birth _____

**CONSENT FOR RELEASE OF INFORMATION FOR REFERRING AND TREATING CLINICIANS
(e.g., therapist, speech and language pathologists, learning specialists)**

To provide effective care, it can be helpful to communicate with clinicians working with you or your child about their observations and concerns. Please indicate below if Dr. Edidin may communicate with any of the following individuals or organizations.

Clinician's Name: _____

Clinician's Address: _____

Clinician's Phone Number _____ Clinician's Email Address _____

I authorize Dr. Edidin to (please check all that apply):

- Collect information from the individual named above
- Disclose information to the individual named above
- Send the final report to the individual named above

Information to be collected and/or disclosed:

I understand that my decision to sign this form is entirely voluntary and I may refuse to sign this form. I have the right to inspect the report to be disclosed. If I do not sign this form, the information will not be disclosed other than by court order or as requested by law. I understand that I may revoke this consent in writing at any time. Any such revocation will have no effect on disclosures made prior to the date the revocation is received

Signature of Parent, Guardian, or Patients (≥18 years old)

Date

Printed Name of Parent, Guardian, or Patients (≥18 years old)

Relationship to Patient

EVALUATION CENTER FOR LEARNING

Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name _____

Date of Birth _____

CONSENT TO SEND QUESTIONNAIRES TO TEACHERS AND/OR SCHOOL STAFF

Name of School: _____

School Address _____

School Phone Number _____

1a. Teacher Name: _____

2a. Teacher Name: _____

1b. Subject Taught _____

2b. Subject Taught _____

1c. Teacher Email Address _____

2c: 1c. Teacher Email Address _____

Other School Staff Name: _____

Other School Staff Email Address _____

I authorize the Evaluation Center for Learning (ECFL) to send questionnaires to my child's school to collect information about my child's functioning in that setting. Dr. Edidin may send questionnaires to my child's teacher(s) and/or other staff members who can provide information about my child's functioning at school. I understand that my decision to sign this form is entirely voluntary.

Signature of Parent, Guardian, or Patients (≥18 years old)

Date

Printed Name of Parent, Guardian, or Patients (≥18 years old)

Relationship to Patient