Authorization for Disclosure/Release of Clinical Information

This authorization was developed to comply with "HIPAA" regulations, 45 CFR parts 160 and 164, as well as 34 CFR 361.

Patients Legal Name: _____ **Date of Birth**: _____ SS#: _____

I hereby authorize Dave Jetson of Jetson Counseling to <u>disclose/obtain</u> the following records for the above named individual.

INFORMATION REQUESTED FROM: _____

I, _____, hereby voluntarily request and authorize you to release to Jetson Counseling the following types of information pertaining to me.

INFORMATION	DETAILS OF INFORMATION TO BE RELEASED	
Medical Records		
Psychological Testing		
Psychological Evaluations		
Psychiatric Evaluations		
Psychiatric Care		
Treatment for Addictions		
Counseling		
Other		

(X) THE INFORMATION WILL BE USED FOR THE PURPOSE OF CONTINUITY OF SERVICES BETWEEN THE HEALTH CARE AGENCIES FOR THE BENEFIT OF _____.

( ) OTHER PURPOSE (Specify)_____

- I understand that I may revoke this authorization at any time by providing a written request to my counselor. I understand that revocation will not affect information that has already been shared.
- I understand that my protected health information (PHI) may potentially be re-disclosed and would no longer be protected by federal privacy regulations.
- I understand that authorizing for this disclosure of information is voluntary and that my signing this form is not required to assure treatment, payment, or other benefits. I may Inspect or obtain a copy of the information to be disclosed as provided in CFR 164.524.
- I will allow a fax or copy of this authorization to be used if needed.
- For non medical releases, I understand that the specified information is necessary in order to provide services and its confidentiality will be respected by JETSON COUNSELING.

This authorization will expire either at the time it is revoked, revised in writing by the CLIENT or after one year, whichever occurs first.

I hereby release the above designated facility from any legal responsibility or liability, which may arise from act I have authorized.

Patient/Legal Representative Signature: _____ **Date** _____

Specify relationship if not patient: _____

Witnessed by: _____ Information released by: _____ (initials) Date: _____