JLM
marriage & family therapy

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

Client Name: _____ **Date of Birth:** _____

Please sign the statement below giving permission for me to communicate with the following individual or agency on your/your child's behalf:

Individual/Agency: _____
Address: _____
City, State, Zip: _____
Phone/Fax: ph: _____ fax: _____

This is to authorize _____ to disclose/obtain *(circle one or both)* the following information about me/my child:

___ Diagnosis and dates of treatment
___ Psychological evaluation/assessment
___ Psychiatric Evaluation
___ Medication records
___ Laboratory results
___ Court/Social Service Documents
___ Treatment Plans
___ Summary of treatment
___ Educational records/testing
___ Relevant treatment records
___ History & physical exam
___ Full record *(except progress notes*)*
___ Psychotherapy notes*
___ Other: _____

The above information will be used for the following purpose(s):

___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Other (specify) _____
___ Case review
___ Updating files

** A separate authorization is required for psychotherapy notes, as defined by HIPAA.*

(CONTINUED ON NEXT PAGE)

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1 and 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by federal or state rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. After one (1) year from the date it is signed this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I agree that a photocopy/facsimile of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:

___ Self ___ Parent/Legal Guardian*
___ Personal Representative* ___ Other: _____

**If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.*

Client Signature: _____ **Date:** _____
(If Client is a minor or is otherwise unable to sign this Authorization, please sign below):

Parent/Guardian/Representative Name: _____
Relationship to Client: _____
Signature: _____ **Date:** _____
Witness Signature: _____ **Date:** _____