Release of Information Consent

** indicates a required field*

*** Client Name Here. (If client is a minor, please put the minor's name here- not the parent's name.)**

*** Your relationship to client:**

- ○ Self
- ○ Parent/legal guardian
- ○ Personal representative
- ○ Other

*** I authorize Jayna Haney, MS, LPC to:**

- ○ Send
- ○ Receive
- ○ Send and Receive

*** The following information:**

- ☐ General information which may include treatment plan, concerns, and progress as well as diagnosis
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes, and treatment or closing summary
- ☐ Other

*** To / From:**

*** Email Address**

*** Phone:**

Purpose- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than specified, please explain:

*** Expiration- Unless sooner revoked, this authorization expires on the following date: (Please put the date for one year out or another date, if applicable.**

Form of Disclosure-

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be offered a copy of this authorization for my records.

Conditions-

I further understand that Jayna Haney will not condition my treatment on whether I give authorization for the requested disclosure.

* **Signature:** _____

I consent to sharing information provided here.

Witness signature (if client is unable to sign):

*** Date:**

Witness Date:

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, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

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