AUTHORIZATION TO RELEASE INFORMATION

Diane T. Jacob, MA, MA, LCMHCA
Grace Counseling, PLLC
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Name_____DOB_____

This form, when completed and signed by you, authorizes and directs the release of otherwise protected information from your clinical record to the person(s) you designate.

I authorize the exchange of information between ***Diane T. Jacob, MA, MA, LCMHCA*** and the following:

1. Name_____Organization_____
   Address_____Phone_____
   City_____State_____Zip_____

2. Name_____Organization_____
   Address_____Phone_____
   City_____State_____Zip_____

Information to be released includes:

_____

_____

_____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with the individuals or companies listed above. It shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of:
_____.

This authorization will remain in effect for two (2) years unless you designate a different time period below. You may revoke this authorization at any time by giving Diane T. Jacob, MA, MA, LCMHCA written notice. I understand that I have the right to revoke this authorization at any time unless action has been taken in reliance upon it.

Expiration if different from above: _____

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

This authorization is fully understood and is voluntarily made on my part.

_____ *OR* _____
Patient's Signature *Parent or Legally appointed representative's signature*

_____ _____
Date of Signature *Relationship if not parent*