

Jennifer Brown, LLC
Licensed Clinical Social Worker
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Authorization for Release of Information

Patient's Name

Birth Date

I understand that this authorization is voluntary. I understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I further understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying my therapist in writing, but if I do, it will not have any effect on any actions my therapist took before she received the revocation.

I authorize Jennifer Brown, LCSW to (check all that apply):

- Exchange with
- Release to
- Obtain from the parties I have indicated below

I authorize Jennifer Brown, LCSW to exchange/ release/ obtain information:

- verbally only
- in written form only
- both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

Phone/Fax/Email: _____

Description of individually identifiable health information to be released/ exchanged/ obtained:

- Treatment Plan(s)
- Outpatient Progress Reports
- All relevant clinical documentation/information my therapist deems appropriate for the purposes checked on this page
- Other _____

The purpose of this release is (check all that apply):

- Treatment coordination
- Subpoena or other legal process
- Other (describe): _____

I understand that this authorization will expire on ____ / ____ / ____.

Parent/Patient's signature

Date

Patient's name

Witness's Signature

Date

You may refuse to sign this authorization.