Jennifer Brown, LLC

Licensed Clinical Social Worker

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Gainesville, GA, 30501

917-494-1410

Authorization for Release of Information

_____ _____

Patient's Name Birth Date

I understand that this authorization if 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 <u>Jennifer Brown, LCSW</u> to (check all that apply):

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

I authorize <u>Jennifer Brown, LCSW</u> 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:_____

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.