Working Together

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Authorization for Release of Information

This form when completed and signed by you, authorizes the designated person or organization to release or obtain protected health information for the following person:

Client Name: _____
Date of Birth:_____/_____/_____

I authorize **Mike Jahn, MA, LMFT** to release the following information verbally and in writing to:

_____

Phone: (_____)_____ Fax: (_____)_____

(* Please initial below the information to be released)

_____ Screening Information _____Behavioral and Psychological Reports
_____ Treatment Plan _____Psychotherapy/Counseling Notes
_____ Other: _____

I authorize:_____ to release the following information verbally and in writing to **Mike Jahn, MA, LMFT**

(* Please initial below the information to be released)

_____ Screening Information _____Behavioral and Psychological Reports
_____ Treatment Plan _____Psychotherapy/Counseling Notesm
_____ Other: _____

I am requesting release of this information for the following reasons:
(* Please initial below the information to be released)

_____ To provide services and care
_____ Other purpose (please specify):_____

This authorization shall remain in effect until (expiration date): _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked, this release shall remain in effect for the period reasonably needed to complete the request. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.
Date:_____/_____/_____

*Signature of Client or Legal Guardian: _____
**If client is under 18 years old, signature of Legal Guardian is required.*

Printed Name of Client or Legal Guardian: _____