Jewish Family & Career Services

JF&CS

Your Tools for Living

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION

LAST NAME:_____ FIRST NAME:_____ BIRTH DATE_____

I hereby authorize Jewish Family & Career Services to: [ ] Release to [ ] Request from

_____

(Name & Phone)

_____

(Address)

_____

(City/State/Zip Code) **(Fax)**

Check appropriate documents to be released or requested:

[ ] Initial Clinical Assessment
[ ] Social History
[ ] Diagnosis
[X] Telephone Reports/Verbal Communications
[ ] Treatment Plan
[ ] Consultations
[ ] Progress Summaries
[ ] Closing Summary/Recommendations
[ ] Psychological Evaluation
[ ] Psychiatric Evaluation
[ ] Compliance with Treatment
[ ] Written Correspondence
[X] Other, please specify_____email_____
{] Classroom Observation
[ ] Ongoing service provided by a cooperating service provider

I authorize _____, an employee and/or designee of Jewish Family & Career Services, Inc., to release information to or to receive information from the above listed organization and/or individual, for the purpose of

_____.

This authorization is valid for ninety (90) days from the date of my signature. However, if "ongoing service" is checked, authorization is valid for <u>one</u> calendar year. "On-going service" applies to current services received at JFCS concurrent with services provided by another service provider.

<u>Conditions</u>

I further understand that JFCS will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

I understand I may revoke this authorization at any time by submitting a written request to the attention of the JFCS Privacy Officer. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

<u>Form of Disclosure</u>

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. (2-sided)

Redisclosure

*Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:*_____

Furthermore, I hereby release Jewish Family & Career Services and its employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of the information authorized above. I understand the records released may contain sensitive materials including alcohol and/or drug information and psychiatric information. I understand that information may be transmitted by electronic means such as by fax and/or e-mail. Portions of the information provided may not pertain exclusively to my current diagnosis.

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

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

_____

Signature of Staff Witness Date

_____Check here if patient/client refuses to sign authorization