Jones Counseling Services

jenjones7337@gmail.com
602-354-0259

Authorization to Disclose Protected Health Information (PHI)

Client Name:_____Date of Birth:_____
I voluntarily authorize Jones Counseling Services to exchange my PHI with: (One person/Organization per form)

Name:_____Relationship to Client:_____
Address:_____
City/State/Zip:_____
Phone Number:_____Fax Number:_____
☐ Mailed ☐ I will pick up ☐ Exchange verbal information

The purpose or need for this disclosure is
Academic/School Placement/Aftercare | Armed Forces/Military | Legal | Continuing Care | Personal use | Employment | Other:

The information to be disclosed:
☐ Discharge paperwork ☐ Initial Assessments ☐ History & Physical Exam Reports ☐ Psychiatric Evaluation
☐ Medication Reconciliation ☐ Lab Reports ☐ Billing Statements ☐ Progress Notes
☐ Other:_____

I understand that the information to be disclosed may include information about medical, psychiatric, drug/alcohol, mental health, social and/or communicable diseases, including HIV/AIDS. I request the following limitations:

DO NOT DISCLOSE:
☐ Alcohol/Drug Treatment/Referral
☐ Sexually Transmitted Disease(s)
☐ HIV/AIDS – related treatments

_____
Signature Time Date

I understand that I may revoke this authorization at any time, by submitting in writing to Jones Counseling Services, except to the extent that actions have been taken. This authorization shall remain in effect for one year from the signature date unless further limitation is set here by the client or legal representation.
Specify New Date: _____

Your rights regarding release of protected health information (PHI)

- I understand that I may refuse to sign this authorization. My signature is voluntary and treatment or eligibility for benefits is not conditioned upon the execution of this authorization.
- I understand that matters discussed on this form and that I can receive a copy of it. I release the provider and company of liability for the disclosure of my information pursuant to this request.
- My records are protected under federal regulation governing Confidentiality which prohibit further disclosure without written consent unless provided by law or regulation.
- If not subject to federal, state, or HIPAA confidentiality regulations, I am aware that the recipient may not re-disclose my PHI without permission.

_____ _____ _____
Client/Responsible Party Signature Time Date

_____ _____ _____
Jennifer Jones, LPC, LISAC Time Date