Authorization for Use and Disclosure of Protected Health Information and /or Confidential Information Jewish Family SERVICES

Client Name: _____Client DOB: _____/_____/_____ Client #: _____

I, _____ (client/guardian), authorize Jewish Family Services (JFS) to disclose private health information to the following:

- ❑ Physician/Psychiatrist – Name _____
- ❑ Family Member(s) – Name _____
- ❑ Insurance Company – Name _____
- ❑ Social Security North Carolina DMA North Carolina MH/SS/SAS
- ❑ Other: _____

Effective Date: _____/_____/_____

Reason for information to be released: Care Coordination

I consent to the release of information or records created by or disclosed to JFS pertaining to the following:

- ❑ Person Centered Plan/Treatment Plans
- ❑ Service Notes/Reports/Updates
- ❑ School Records
- ❑ Psychological Reports
- ❑ Immunization/Medical Records
- ❑ Assessments
- ❑ Admission/Intake/Discharge Information
- ❑ Written & Verbal Communications Pertinent to Treatment for Couple's Medical Record Only. *Each individual client will not be able to access the other individual's record.*
- ❑ Other (Please be specific): _____

PLEASE INITIAL THE FOLLOWING:

_____ I understand that the information disclosed may have been created by JFS or released to JFS by other agencies (i.e. re-release).

_____ I understand that information disclosed regarding my treatment may include (if applicable) information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

_____ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that the provider cannot deny or refuse to provide services.

_____ I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.

If not revoked earlier, this authorization expires on: _____/_____/_____, not to exceed one year of signature date.

Signature of JFS Client/Guardian: _____ Date_____/_____/_____

Please Print Name: _____

Name of JFS Staff Member Who is Providing Services: _____

Administrative Use Only

This authorization was revoked on _____/_____/_____ by: _____per JFS Staff: _____