Jay D. Fellers, LCSW PC

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AUTHORIZATION TO RELEASE PROTECTED HEALTH AND CONFIDENTIAL INFORMATION

I, _____, authorize the following person(s)/entity and Jay D Fellers LCSW PC to exchange my protected health and confidential information for the below stated purposes:

Name: _____

Address: _____

Tel.: _____

Fax/Email: _____

Relationship
To Client: _____

INFORMATION REQUESTED: I authorize the exchange of information with the above named person(s)/entity and CSC (check all that apply):

□Evaluations
□Medical/Mental Health Records
□Medications Prescribed
□Drug &/or Alcohol Abuse Information
□School Records
□Psychotherapy Notes
□Treatment Summary/Plan Reports
□Diagnosis/Psychiatric Conditions
□Testing/Assessments
□ Child Protection, Dept. Human Services, &/or Probation Records

Other: _____

The information requested may include records, verbal communications, and/or electronic communications such as texts or emails. The information may be released (check all that apply):

□ verbally □ writing □ photocopy □ electronically (such as email) □ fax □ mail

I understand that the information to be released includes information for the following purpose(s):

□ Coordination of Care/Treatment □ Medical Care □ Evaluation/Assessments
□Legal Issues □Supervision

Other: _____

The information sought in this request is the minimum necessary to accomplish the intended purpose of the request. 45 C.F.R. 164.502(b)(2)(v). (See 65 FED. Reg. 82530).

I understand that this authorization will expire in two (2) years from the date of signing, unless otherwise specified here:_____

AUTHORIZATION: I understand and certify that this disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits, unless specified in this form. I certify that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer, Jay D Fellers, at the contact information above, or his designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. I understand and authorize the disclosure of my mental health information is being made to someone who may or may not be legally required to keep it confidential, and that it may be re- disclosed and may no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a reasonable fee will be charged for copies of my mental health record. I understand the facility will provide me a copy of the signed authorization form upon my request. If I have questions about disclosure of my mental health information, I can contact the facility Privacy Officer or their designee. I understand that treatment may not be denied if I refuse to sign this authorization, except: 1) If the authorization is the very reason for seeking the health care; or 2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign the authorization: 1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and 2) If the authorizing is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes. I understand and affirm, by my signature below, that the benefits and disadvantages of releasing the above information, if known, have been explained to me. A copy or telefax of this authorization will be as valid as the original.

_____ _____ _____

Client or Parent/Legal Guardian/Rep. Signature (& Relationship to Client)

Date

**The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.