Jay D. Fellers, LCSW PC

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RELEASE OF INFORMATION

_____ _____
Client Name Date of Birth

I, _____ authorize JAY D FELLERS LCSW PC to obtain information from & share information with the parties listed below. I give the party below my permission to release all information relevant to my treatment, including information that was not created by them but has been released by them:

The information exchanged my include:
_____psychiatric history, including diagnosis and treatment
_____admission history, physical, discharge summary, operative reports
_____psychological, neurological testing & consultation
_____physical exam, lab studies, xrays, EKG, EEG
_____drug/alcohol history & treatment
_____educational material
_____all of the above information
_____other:_____

The information may be used for:
_____assessment
_____continuity of care
_____service planning
_____all of the above
_____other:_____

I understand that I may revoke this authorization to release/request information at any time by giving written notice to JAY D FELLERS LCSW PC. Without such revocation, this authorization shall expire on ___/___/___, or if left blank, six months following termination of treatment. I release JAY D FELLERS LCSW PC from any liability for releasing such information.

_____ _____ _____
Client/Parent/Legal Guardian Signature Date Witness Signature

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without specific consent of the person to whom it pertains.

A copy or facsimile of this authorization is as valid as the original.

I hereby revoke this Authorization to Release/Request Information.

_____ _____ _____
Client/Parent/Legal Guardian Signature Date Witness Signature