JYDES FAMILY CLINIC

Behavioral Health Practice

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name: _____

Client Address: _____

City : _____ State: _____ Zip:_____

Date of Birth: _____

I, the above-named patient (or other person authorized to execute this authorization on the patient's behalf), hereby authorize Jydes Family Clinic **to release to or obtain from** information and/or medical records described below:

_____

(Name of Individual, Institution or Agency)

_____

(Address, including City, State, Zip, Phone and Fax)

Reason for Disclosure:

____ Continuation of Care
____ Attorney
____ Social Security
____ Insurance
____ Other (Specify Below)
Communication: _____

Information to be Released:

____ Discharge Summary
____ Progress Notes
____ Assessments
____ Other (Specify Below)
____ Verbal

I understand that the medical records described below were compiled in connection with treatment received by the above-named patient at Jydes Family Clinic and that the records may contain information which is deemed to be privileged or confidential under either State or Federal Law and Regulations. (42 CFR, Part 2).

I hereby release Jydes Family Clinic, its officers, trustee, agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized above. I hereby waive any therapist-patient privilege with respect to records released to the above name individual or agency and likewise waive any privilege concerning records of infectious or contagious disease and/or drug or alcohol abuse or treatment of same. I acknowledge that this consent is valid for 365 days from the date this consent is executed by me unless sooner revoked by me in writing delivered to Jydes Family Clinic. I further understand that the consent may be revoked but not retroactive to release of information above.

I give permission for information to be shared in house about the above-named individual.

Signature of Patient/Authorized Representative: _____

Representative's Relationship to Patient: _

Date Signed: _____