AUTHORIZATION FOR RELEASE OF INFORMATION

Date of Birth ____/ ____/ ____

I, _____, hereby give my authorization for **Jackie L Stout, LCSW** to disclose to and/or obtain information about me from:

Name:_____

Phone Number:_____ Fax:_____

Description of Information to be Disclosed

I authorize the individuals listed above to use, obtain or disclose the following information (please INITIAL each item):

___ Assessment
___ Diagnosis
___Psychosocial Evaluation
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Medication Management Information
___ Treatment Presence or Participation
___ Nursing/Medical Information
___ Educational Information
___ Discharge/Transfer Summary
___ Continuing Care Plan
___ Treatment Progress
___Demographic Information
___Psychotherapy Notes (Cannot be combined with any other disclosure)
___ Other_____ ____ Other_____

Purpose

The disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. Unless otherwise specified by (please checking all appropriate boxes)

☐ If disclosure is for **other** than marketing, sale of information, research or as specified above, please specify:_____

☐ If disclosure is for **marketing** purposes, please set forth the financial remuneration amount received by Jackie L Stout, LCSW in exchange for disclosing the information $_____

☐ If disclosure is for research purposes, please identify the current and future research studies as whether each research study is conditioned upon execution of the authorization and client's ability to opt in or opt out of each study:
_____

☐ If disclosure is for the sale, license to use or lease of the information, please list each recipient's names
_____

Expiration

This authorization will expire unless revoked sooner (please check ONLY one box)

☐ Upon the completion/termination of treatment with the current provider
☐ Upon the following date, event, or condition _____

Acknowledgement of Limitations & Rights Regarding Authorizing Disclosure

- **I understand that the duration of consent shall be consistent with the limitations identified under the "Expiration" portion of this form.** I understand that after that specified expiration condition is met, no more

information can be used or released to the person or organization identified above unless a new Authorization for Release of Information for is signed.

- I understand that I can revoke or cancel this authorization for release of information at any time by submitting a written notification to **Jackie L Stout, LCSW**. If I do this, it will prevent any releases after that date it is received, but cannot change the fact that some information may have been sent or shared prior to that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Jackie L. Stout, LCSW.
- I understand that unless I specifically request in writing that the disclosure be made in a certain format, Jackie L Stout, LCSW reserves the right to disclose information a permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA priacy regulations, unless Virginia state law applies that is more strict than HIPAA and provides additional privacy protections..
- I affirm that everything in this form that was not originally clear to me has been explained and I believe that I now understand all of it.

Client Consent to Authorize the Release of Information

Print Client Name _____ Date _____

Print Parent/Guardian/Legal Representative Name (if applicable) _____

Signature of Client (parent/Guardian/Legal Representative):_____

Please describe your Legal Representative Authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

A copy of this authorization for my records will be provided upon my request.

☐ Check here if client refuses to sign authorization

Signature of clinician/witness _____

Print Name _____ Date _____

A photocopy of this completed release is considered to be as valid as the original document.