Jessica & Michael
Counseling and Consulting LLC

Submit

www.Jessicaandmichaellmhc.com

Jessica Turner MS, LMHC, CATP, CCTP-II
Jessica.Turner@jessicaandmichaellmhc.com
813.530.8175

Michael Kyser MA, LMHC, CCTP-II
Michael.Kyser@jessicaandmichaellmhc.com
863.272.1960

# Authorization for Release or Exchange of Confidential Information

Patient:_____ Date of Birth: _____

I authorize Jessica & Michael Counseling and Consulting LLC to release / receive the following information (check all that apply):

- ☐ Results of psychological and or education testing
- ☐ Counseling / psychological treatment
- ☐ Psychiatric
- ☐ Medical information
- ☐ Educational
- ☐ Legal
- ☐ Other information (Specify:_____)

I authorize Jessica & Michael Counseling and Consulting LLC to exchange the specified information with the following entity:

Name/Agency:_____

Address: _____

_____

Phone / Fax: _____

Purpose of disclosure:

- ☐ Continuing care
- ☐ At the request of client / client's parent/guardian
- ☐ Other (Specify:_____)

This authorization shall remain in effect until: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification with signature to my email. However, your revocation will not be effective to the extent that Jessica & Michael Counseling and Consulting LLC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Jessica & Michael Counseling and Consulting LLC generally may not condition services upon my signing an authorization unless the services provided to me are for the purpose of creating health information for the third party.

I understand information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

X _____ X _____

Client (13 or Older) Client Print Name

X _____ X _____

Witness Witness Print Name

X _____ X _____

Parent/Guardian or Authorized Representative Parent/Guardian or Authorized Representative Print Name