Jessica L. Long, Psy.D.

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Authorization to Release Protected Health Information (PHI)

CLIENT NAME: _____ CLIENT's **DATE OF BIRTH**: _____

If Applicable: Previous Name(s): _____ Parent/Guardian: _____

I AUTHORIZE the office of **Jessica Long, Psy.D.**:

_____ ***To DISCUSS with or RELEASE my records TO: and/or*** _____ ***To DISCUSS with or RETRIEVE my records FROM:***

INSTITUTION/AGENCY/PERSON:		Contact Person:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	

INFORMATION TO BE RELEASED OR DISCUSSED: (Check all that apply)

☐ **All** mental health and medical healthcare information about me, including my clinical records. I understand this information may include, if applicable: information about mental health diagnosis or treatment; information about diagnosis or treatment for alcohol or drug abuse, information about diagnosis or treatment of HIV/AIDS or Sexually Transmitted Diseases.

☐ **All educational** records including school staff observations and behavior ratings, evaluations, report cards, behavior records, 504 plans, and IEP's and/or _____

☐ **Legal** and court documents: _____

☐ **Specific** information: ____ Psychological Report ____ Treatment Summary including diagnosis/recommendations
____ Billing/scheduling Info ____ Letter re: _____ **and/or**
____ Other: _____

FOR DATES OF SERVICE: ____ All dates on file ***OR*** ____ Services provided between _____ and _____
(check only one)

PURPOSE OF RELEASE: ____ Administrative ____ Evaluation ____ Treatment Planning ____ Educational Planning **and/or**
(check all that apply) ____ Other _____

THIS AUTHORIZATION ENDS: ____ One year from signature date
(check only one) ____ When the following occurs: _____ (e.g., Release is rescinded)

- My cancellation or refusal to sign this authorization will not affect the commencement, continuation, or quality of my treatment.
- I understand that I may refuse to sign or I may cancel this authorization at any time, in writing, as allowed by law, except if disclosure is made to obtain payment, treatment, operation, or as stated in the Office Policies document received during my intake. To cancel an authorization, I can make a formal request in writing sign, date, and write "Cancel" on this original form. Prior actions already taken by Jessica Long, Psy.D. in reliance upon my original request will not be affected.
- Once my PHI is disclosed, the office of Jessica Long does not have control over it. PHI is sometimes disclosed to those not required to comply with federal privacy protections and may be re-disclosed without my permission. I release the office of Jessica Long from any and all legal liability that may arise from the use and disclosure of information as set forth in this authorization.
- There may be charges associated with my request for records.

_____ _____
Client Signature (If client is 13 years of age or older, he/she must sign consent) Date

_____ _____
Parent/Guardian Signature (for minors 12 years of age and under) Date

Office Use Only: ____ File ____Fax/Mail ___ Request Phone Call ____ Request Records ____ Send Rating Scales