Release of Information

Client Name:_____ **Date of Birth:** _____

I authorize that the requested information may be ❒ released to ❒ received from

Name of person / provider / organization / facility or program	Contact Name for Organization / Facility / Program
Street Address	City, State, Zip Code
Phone Number	Fax

I authorize that the requested information may be ❒ released to ❒ received from

Kristie Jewitt, MS, LMFT, PLLC Name of person / provider / organization / facility or program	**Kristie Jewitt, MS, LMFT** Contact Name for Organization / Facility / Program
130 Allens Creek Road Street Address	**Rochester, NY 14618** City, State, Zip Code
(585) 244-4161 EXT 6 Phone Number	Fax

Purpose of this Request (Check one)**:**

❒ Healthcare ❒ Insurance coverage ❒ Discharge Planning ❒ Housing ❒ Disability Determination ❒ Personal ❒ Other _____

Specific Information Authorized (Select one or more as appropriate)**:**

❒ Assessments	❒ Progress Notes	❒ Laboratory Test Results: _____
❒ Diagnostic Impression	❒ Discharge Summary	❒ Diagnostic Test Results: _____
❒ Treatment Plans	❒ Educational Information	❒ Other: _____
❒ Treatment summary (include history/physical, laboratory tests & x-ray reports) _____		
❒ Entire copy of the inpatient/outpatient record checked above.		

One-time Use / Disclosure:

I authorize the one-time use or disclosure of the information described above to the person / provider / organization / facility / program(s) identified. **My authorization will expire:**

❒ When the requested information has been sent/received

❒ 90 Days from this date ❒ Other: _____

Periodic Use / Disclosure:

I authorize the periodic use/disclosure of the information described above to the person / provider / organization / facility / program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire:**

❒ When I am no longer receiving services from Kristie Jewitt, MS, LMFT

❒ One year from this date. ❒ Other: _____

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.
- I may cancel this authorization at any time by submitting a **written** request to the Strong Health Program address above, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization.
- If the medical record information is not sent to another care provider there may be a charge for the requested records.

Signature of Client or Guardian (if under 18) _____ **Date** _____

Witness _____ **Date** _____