Jane Ridgway, MA, LPC, NCC

1701 Gateway Blvd. E. Ste 385, Richardson, TX 75080
Phone 21.662.7317 Email Jane.fxfocus@gmail.com

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION*

PATIENT'S NAME: _____ BIRTH DATE:_____ ___

I, _____, residing at _____, hereby give my consent to Jane Ridgway MA, LPC, NCC, and Function Focus Counseling PLLC to release and receive personal health information contained in my Clinical Record regarding:

Mental health: _____

Medical history: _____

Family history: _____

Other: _____

to/from:

Recipient/Provider of Confidential Info: _____
Relationship to Patient: _____
Phone Number(s): _____ Fax: _____
Address:
_____

Recipient/Provider of Confidential Info: _____
Relationship to Patient: _____
Phone Number(s): _____ Fax: _____
Address:
_____

for the purpose of ("continuity of care" if left blank):
_____

I understand that this is valid until (indefinite if left blank) _____, that I may withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

_____ _____
Patient Signature Date

(Compliant with the Health Insurance Portability and Accountability Act (HIPAA)