Jennifer Moné, Ph.D., PLLC
Licensed Marriage & Family Therapist
EMDR Practitioner

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Individuals ● Couples ● Families ● Children ● Teens

Release of Information and HIPAA Authorization/NOTICE OF PRIVACY PRACTICES

As a psychotherapist, I recognize the importance of clients sharing information about their life experiences. Much of what I know comes directly from my clients in the open and trusting therapeutic relationship.

Your records are protected under Federal and specific State Confidentiality laws and cannot be disclosed without your written consent, unless otherwise provided for in the regulations. By signing below, you give permission for Jennifer Moné, Ph.D., PLLC to discuss information you have shared. You are entitled to inspect your records, and may do so with a written request. You may revoke this consent at any time by submitting a written request. By signing the form, you understand there is potential for the information disclosed to be subject to re-disclosure by the organization that obtains the information. Unless otherwise indicated, this consent to release information will expire one year from the date you sign this form. Finally, by signing this form, you also acknowledge a copy of these privacy practices were offered to you.

I/We, _____ have read and understand the above statement
(Client name[s])

and authorize the mutual exchange of information between Jennifer Moné, and Conceptions Reproductive Associates. (Or, add other organization names here:)

The information to be shared regarding _____ includes the following: (please specify)
(Client name[s])

_____ pertinent information regarding history, medical treatment records, psychological and educational evaluations, diagnosis, and similar information from my file.

OR
_____ (write in) _____

_____

Unless otherwise noted here, this authorization will expire a year from the date signed below.

_____

_____ _____
Client's signature Date

_____ _____
Client's signature Date