Jackson Counseling Solutions

Authorization to Release Health Information

Client Name: _____ **DOB:** _____

I hereby authorize Jackson Counseling Solutions, LLC/ Stacey Jackson, LICSW to:

___Release to ___Obtain from ___Communicate with

Agency/Person:_____
Phone:_____ Fax:_____ Email:_____
Address:_____
The following information pertaining to treatment from: _____to_____

___financial, billing, insurance, and/or demographics related information
___Scheduling and appointments
___Treatment Plan
___Intake/Progress Notes
___Participation in family/couples session with client present
___Participation in family/couples session without client
___Other:_____

Purpose for Disclosure: _____

I understand that this authorization will automatically expire one year from the date signed. I authorize the transmission of my health records in situations where this information is needed for continuing care. This release of information can be revoked by the client at any time. Further release of this information is prohibited unless written consent of the client (or their guardian).

___e-signature via Therapy Notes ___Self

_____ _____

Signature of Client/Guardian Relationship to Client

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