AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of health information, this notice informs you of the purpose of the form and how it will be used.

PRINCIPAL PURPOSE(S): This form is to provide **JCW Mental Health LLC Center** with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual, **within 3 to 5 BUSINESS days**, for: personal use; insurance; treatment or continued medical care; school; legal; retirement/separation; or other reasons as specified below.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the medical records.

Client Name: ______________________________ Date of Birth: _____/______/______
mm dd yy

□ I am the client and hereby authorize the use or disclosure of health information, including protected health information, about me as described below.
□ I am the client's representative and understand and agree to the provisions of this authorization on behalf of the patient. My authority to act on behalf of the patient is as follows:

____

By signing this form, I authorize the release of health information, including protected health information. I authorize JCW Mental Health LLC to:

□ disclose to ______________________________ obtain from ______________________________

Please enter
Provider's name
& Contact information __________________________

Please enter
provider's name
& contact information ______________________

INFORMATION MAY BE DISCLOSED BY: **JCW Mental Health LLC** and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

INFORMATION TO BE DISCLOSED:

General Medical Record(s), including Progress notes, Consultations, History and Physical, Immunizations, Family Planning, Prenatal Records, Laboratory Test results, Diagnostic Test Reports.
Other: (specify) ______________________________ Specify dates of service: ____________________

PURPOSE OF DISCLOSURE:

□Treatment □Personal Use □Billing/Payment □Continuity of Care
Other (specify): _________________________

Patient Signature/Guardian: ____ Date: _________________