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AUTHORIZATION TO RELEASE / RECEIVE / EXCHANGE CONFIDENTIAL RECORDS AND INFORMATION

For Clinical Psychological Evaluations, Treatment-Related Releases, and Forensic/Court-Related Evaluations

This form authorizes Dr. Zhujun "Jackie" Jiang, PsyD, and/or Dr. Jackie Jiang & Associates, LLC to release, receive, and/or exchange records and information for the purpose(s) checked below. This authorization may be used for clinical, forensic, legal, administrative, educational, medical, disability-related, employment-related, immigration, adoption/surrogacy, capacity, fitness-for-duty, or other professional evaluation or consultation purposes.
This authorization is intended to comply with applicable confidentiality laws, including HIPAA where applicable, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110, 42 CFR Part 2 where applicable, and other laws governing specially protected information.

Client Name: _____ Birth Date: _____
(Please print)
Parent/Guardian Name (if applicable) _____ Birth Date: _____
(Please print)

Check all that apply. I authorize Dr. Zhujun "Jackie" Jiang, PsyD, and/or Dr. Jackie Jiang & Associates, LLC to: ☐ **RELEASE** ☐ **RECEIVE** ☐ **EXCHANGE** information verbally, electronically, or in writing with the person or entity listed below.
Name/Organization: _____ Relation/Role: _____
Address: _____Phone: _____
Email: _____ Fax: _____
Specific communication restrictions, if any: _____

Purpose of Disclosure / Exchange (check all that apply):

☐ Clinical, diagnostic, educational, developmental, medical, occupational, disability-related, treatment-related, referral-related, school-planning, accommodation-planning, care-coordination, consultation, or documentation purpose.
☐ Forensic, legal, administrative, court-related, immigration-related, adoption/surrogacy-related, guardianship/capacity-related, disability-related, employment-related, fitness-for-duty, FOID, military/medical-clearance, FMLA/second-opinion, child custody/parenting-time, parenting-capacity, Rule 215, collateral-review, or other legally relevant evaluation, consultation, documentation, report, testimony, or proceeding.
☐ Other purpose: _____

Information Authorized for Release / Receipt / Exchange *

☐ **Psychological evaluation report**(s), including diagnostic impressions, clinical findings, testing summary, behavioral observations, relevant history, collateral summary when applicable, recommendations, and related information necessary to understand the evaluation conclusions.
(*Raw test data, test protocols, item-level responses, scoring materials, test booklets, test stimuli, and protected psychological testing materials are not routinely released due to test-security requirements,*

copyright restrictions, professional standards, and applicable law, and may be released only to qualified professionals or when legally required.)

☐ **Treatment-related** records or summaries, including treatment plans, progress summaries, discharge summaries, dates of service, attendance, participation, compliance, treatment status, and coordination-of-care information. Date(s) of Service, if applicable, from _____ to _____

☐ **Limited letter or summary**, such as dates of service, purpose of evaluation or treatment, diagnosis when applicable, recommendations, progress/status, or functional findings.

☐ **Psychiatric, medical, hospital, medication, physician, inpatient, outpatient,** or other health-related records relevant to evaluation, treatment, functioning, safety, diagnosis, impairment, or recommendations. Date(s) of Service, if applicable, from _____ to _____

☐ **School,** academic, educational, IEP/504, accommodation, attendance, disciplinary, teacher-report, developmental, or testing records.

☐ **Billing**, payment, scheduling, appointment attendance, or administrative records.

☐ **HIV**-related information, genetic information, or other specially protected information contained in the records.

☐ Other: _____

☐ **Do NOT release** the following information: _____

*Substance-use disorder treatment records subject to 42 CFR Part 2 require a separate compliant authorization before release.

Rights and Important Disclosures

By signing this form, I understand and agree to the following:

a. Signing this authorization is voluntary unless disclosure is required by court order, subpoena, law, legal process, agency requirement, referral requirement, or the terms of a forensic, legal, administrative, or court-related evaluation.
b. Refusing to sign may limit Dr. Jiang's ability to complete an evaluation, coordinate care, communicate with collateral sources, issue a report, respond to referral questions, or provide requested documentation.
c. I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it or disclosure is required or permitted by court order, subpoena, law, legal process, agency requirement, referral requirement, or other legally authorized process.
d. Once information is disclosed to an authorized recipient, Dr. Jiang and Dr. Jackie Jiang & Associates, LLC cannot guarantee that the recipient will not re-disclose it. Some recipients may not be bound by HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, or other confidentiality laws.
e. I have the right to inspect and copy the information authorized for disclosure as permitted by applicable law.
f. Forensic, legal, administrative, and court-related evaluations are not confidential in the same manner as psychotherapy or routine clinical treatment. Information may be disclosed as permitted or required by the referral purpose, written authorization, court order, subpoena, legal process, agency requirement, or applicable law.
g. Psychotherapy/process notes are not included in this authorization unless separately authorized in writing or required by court order or law.
h. Psychological test materials may be protected by copyright, test-security rules, and professional standards. Raw test data and protected test materials may be released only to qualified professionals or as required by law, court order, or professional standards.

i. This authorization does not require Dr. Jiang to release information she is not legally or ethically permitted to release, including information protected by court order, law, privilege, third-party confidentiality, test-security restrictions, copyright restrictions, or professional standards.
j. No sale of protected health information is authorized by this form. Dr. Jiang and Dr. Jackie Jiang & Associates, LLC will not receive payment from a third party for the disclosure of this information, except ordinary fees for evaluation, record preparation, copying, testimony, consultation, administrative processing, or professional services when applicable.

Expiration

This authorization expires on the following calendar date: _____/_____/_____. If no expiration date is written above, this authorization will be treated as valid only on the date received by Dr. Jackie Jiang & Associates, LLC, unless otherwise permitted by applicable law or legal process.

Acknowledgement

By signing below, I represent that I am the client/examinee, the parent/legal guardian of a minor client/examinee, or another legally authorized representative with authority to sign this authorization. If signing for another person, I agree to provide supporting documentation upon request.

Client Name (print): _____
Client Signature: _____ Date of Signature: ____/____/_____

Parent / Legal Guardian / Authorized Representative Name (print): _____
Parent/Guardian/Authorized Representative Signature_____ Date: ____/____/_____

Witness/Staff Name (print): _____ Title: _____
Witness Signature: _____ Date of Signature: ____/____/_____