Dr. Jackie Jiang Counseling and Evaluation, LLC
910 W. 35th St., Davenport, IA, 52806
Ph: 563-844-5366 Fax: 309-403-0554
https://drjackiejiangandassociates.com/

Request/Authorization to Release Confidential Records and Information

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act 740ILCS 110 et seq., Aids Confidentiality Act, 410 ILCS 305 et. Seq., the Alcoholism and Other Drug Abuse and Dependence Act, 20 UKCS 30 1/30-5 BB, and the Health Insurance Portability and Accountability Act (HIPAA, 1996).

Name: _____ Birth Date: _____
(Please print)
Minor Name_____ Birth Date: _____
(Please print)

I authorize Olivia Hedden, LMHC to □ release to □receive from □exchange
the following protected information from my, or my child's, clinical record with

_____

_____

_____

(*Name, organization, addresses & phone number*)

Release only those portions of the record checked below:

☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:
Date(s) of Service: from _____ to _____
☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
☐ Treatment plans, recovery plans, aftercare plans.
☐ Workshop records and other vocational evaluations and reports
☐ Academic or educational records.
☐ Psychiatric evaluations, reports, or treatment notes and summaries
☐ Admission and discharge summaries
☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
☐ Billing records
☐ A letter containing dates of treatment(s) and a summary of progress
☐ HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: □ Do not release
☐ Other: _____

I FULLY UNDERSTAND THE FOLLOWING:

My mental health records and/or information in connection with the dates stated above may contain mental health, development disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS/HIV) test results and/or other information.

I authorize the source named above to speak by telephone with Ali Brown, LCPC any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

I consent that no services will be denied me/the patient solely because I refused to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 180 days, or on _____ (a specific date, whichever is sooner) from the date I signed it.

I agree that a photocopy of this form is acceptable.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

I understand that once my health information is disclosed to the recipient it cannot be guaranteed that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and Illinois law governing the use and disclosure of my health information. I understand that the disclosing party may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

Client Signature: _____ Date of Signature: _____

Guardian Signature: _____ Date of Signature: _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Witness Signature: _____ Date of Signature: _____