Dr. Jackie Jiang & Associates
1586 37th Ave, Moline, IL 61265
Ph: 309-944-7833 Fax: 309-403-0554
www. drjackiejiang.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).

Client Name: _____ Birth Date: _____ SSN: _____
(Please print)

Parent/Guardian Name for Minor Client: _____ Birth Date: _____
(Please print)

I authorize Megan Heffernen, LCSW 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 client'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 Dr. Jackie Jiang & Associates any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment, being evaluated, or being referred elsewhere.

I consent that no services will be denied to me/the client 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 client. The information disclosed may be used in connection with my/the client'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 on behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. 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 expire in 1 year on _____.

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/the client's health information is disclosed to the recipient it cannot be guaranteed that the recipient will not re-disclose my/the client's 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/the client's 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/the client's health information.

Client Signature: _____ Date of Signature: _____

Parent/Guardian Signature: _____ Date of Signature: _____

I, a mental health professional, have discussed the issues above with the client 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: _____