AUTHORIZATION TO RELEASE / RECEIVE / EXCHANGE CONFIDENTIAL INFORMATION

Treatment Records • Psychological Evaluation Reports • Testing-Related Records • Forensic/Court-Related Evaluations

This authorization allows Dr. Jackie Jiang & Associates, LLC, including the applicable treating/evaluating clinician(s), psychologist(s), supervisor(s), supervisee(s), and authorized administrative/records staff, to release, receive, and/or exchange the records and information checked below. This authorization is intended to comply with applicable federal and state confidentiality laws, including HIPAA, Illinois and Iowa mental health confidentiality laws, and 42 CFR Part 2 where applicable.

1. Client / Examinee Information

Client/Examinee Name: ___________________________________ Birth Date: ___________________

Parent/Guardian/Representative Name, if applicable: _______________________________ Birth Date: ___________________

Authority to Sign, if not client/examinee: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Court-Appointed Representative

☐ Other: _________________

Clinician Name: ______________________________________

Service Type: ☐ Treatment ☐ Psychological Testing/Evaluation ☐ Forensic/Legal ☐ Other ________________________

2. Direction of Authorization and Recipient (check all that apply):

☐ **RELEASE** information to ☐ **RECEIVE** information from ☐ **EXCHANGE** information with the person/entity below.

Name/Organization: ____________________________________ Relationship/Role: __________________________

Address: ____ Phone: __________________________

Email: ____ Fax: _____________________________

3. Purpose of Disclosure / Exchange

☐ Treatment, coordination of care, referral, consultation, or medical/medication coordination.

☐ Psychological testing/evaluation, diagnostic evaluation, educational/developmental evaluation, or accommodation planning.

☐ Forensic, legal, court-related, custody, disability, employment, FOID, fitness-for-duty, administrative, or collateral-review purpose.

☐ Billing, insurance, payment, scheduling, or records-processing purpose.

☐ Other: ____

4. Information Authorized

☐ Treatment records or summaries, including diagnosis, dates of service, treatment status, progress/discharge summaries, and coordination-of-care information. Dates of service: from __________ to __________.

☐ Psychological evaluation report(s), testing summary, diagnostic impressions, findings, recommendations, and relevant history/collateral summary.

☐ Limited letter or summary. Specify contents: ____

☐ Medical, psychiatric, medication, hospital, physician, inpatient, outpatient, or other health-related records.

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

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

☐ Specially protected information, if applicable and legally permitted: ☐ HIV/genetic information ☐ substance-use-related information ☐ other: _______________.

☐ Other specific records: ____

☐ Do NOT release: ____

If "Other" is checked, the specific information must be described. A blank or generic description is not sufficient.

5. Important Limits and Special Protections

Testing materials. Raw test data, test protocols, item-level responses, test booklets, stimuli, scoring materials, copyrighted testing materials, and other protected test materials are not routinely released and may be released only as permitted or required by law, court order, professional standards, or to a qualified professional when appropriate.

Psychotherapy/process notes. Psychotherapy notes/process notes are not included unless separately authorized in writing or required by law/court order.
42 CFR Part 2. Records protected by 42 CFR Part 2 require a separate compliant authorization before disclosure. This form alone does not authorize release of Part 2-protected substance-use-disorder treatment records.
Legal/forensic matters. Forensic, legal, administrative, court-related, custody, disability, employment, FOID, fitness-for-duty, and similar evaluations are not confidential in the same manner as routine treatment or psychotherapy. The applicable clinician/evaluator may review legal, forensic, custody, or adversarial requests before disclosure to determine whether disclosure is legally, ethically, and professionally appropriate.

6. Rights and Acknowledgements

By signing this authorization, I understand that:

a. Signing is voluntary unless disclosure is required or permitted by court order, subpoena, legal process, applicable law, agency/referral requirement, or the terms of a forensic, legal, or court-related evaluation.
b. 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 otherwise required or permitted by law or legal process.
c. Information disclosed to an authorized recipient may be redisclosed by that recipient and may no longer be protected by HIPAA or state confidentiality laws.
d. This authorization permits but does not require disclosure. The practice/clinician may limit or decline disclosure when legally, ethically, clinically, or professionally appropriate.
e. This form does not authorize the sale of protected health information.

7. Expiration

This authorization expires on: ______/_______/20_______. If no date is written, it expires one year from the date signed, unless a shorter period is required by law or the stated purpose. For forensic, court-related, custody, disability, employment, FOID, fitness-for-duty, or administrative matters, this authorization may expire upon completion of the stated purpose or final resolution of the related matter, unless revoked earlier.

8. Notice to Recipient / Redisclosure Warning

Information disclosed under this authorization may be protected by federal and state confidentiality laws. Further disclosure may be restricted or prohibited unless authorized by the client/examinee or legal representative, or otherwise permitted by law. If this disclosure involves Iowa mental health information, the recipient is specifically advised that redisclosure is restricted under Iowa law.

9. Signature

By signing, I state that I am the client/examinee or have legal authority to sign for the client/examinee. If signing for another person, supporting documentation may be required before records are released.

Client/Examinee Name (print): ____ Date: ____/____/________
Client/Examinee Signature: ____ Date: ____/____/________
Parent/Guardian/Authorized Representative Signature, if applicable: __________________________________ Date: ____/____/________

Office Use Only / Disclosure Documentation

Complete when records are released, received, or exchanged. For Iowa records/disclosures, this section must be completed.

Received by: _________________________ Date received: _____/_____/________ Identity/authority verified: ☐ Yes ☐ No ☐ N/A
Method: ☐ Fax ☐ Mail ☐ Email ☐ Portal ☐ Pick-up ☐ Other: ___________________
Disclosure completed by: ______________________________ Date disclosed: _____/_____/________
Recipient/entity: __________________________
Notes: ____