LaQuanda Jefferson MA., MFTI, NP
Owner/Psychotherapist
Familial Bonds LLC Psychotherapy and Consultation Services
"We believe in you"

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. I hereby authorize _____ to RELEASE my protected health information (PHI) to: _____ I hereby authorize _____ to OBTAIN my protected health information (PHI) from: _____

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Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

- Face sheet
- History & physical
- Laboratory/diagnostic testing results
- School information
- Discharge summary
- Medication records
- Behavioral health/psychological consult
- Psychosocial assessment/Family history
- ER record report
- Psychiatric evaluation
- Substance abuse treatment records
- HIV/AIDS lab results & treatment history
- Progress & Case Notes
- Summary of treatment records & contact dates
- Psychological evaluation/testing results
- Other:_____

- Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by _____without my written consent. I understand that this authorization will remain in effect for:

(Check only one)

- The period necessary to complete all transactions on accounts related to services provided to me.
- One (1) year
- Other:_____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I further verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative Date

_____ _____

Witness Date

P. O Box 5191 Douglasville, Ga 30154 (678) 468-0442
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"Achieving long-standing results for individuals and families"

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