CLIENT REQUEST FOR INFORMATION FORM

Instructions: Fill out this form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Client Name: ______________________ Date of Birth: __________

Current Address: ______________________

Phone/Cell Number: ______________________ Fax Number: __________

I AM AUTHORIZING RECORDS TO BE OBTAINED, RELEASED, AND/OR DISCLOSED FOR DATES: From: __________ To: __________

Only information obtained or created during the date range provided above will be disclosed.

PURPOSE OF RELEASE: (check all that apply)

☐ Coordination of Care ☐ Other, Specify: __________

☐ Personal Records

INFORMATION TO BE RELEASED: (check all that apply, and please be specific)

☐ Letter Summarizing Services ☐ Other, Specify: __________

☐ Copy of Documentation in Record, Specify: __________

LEGAL AUTHORITY: Please review the information carefully. If information is missing the request may not be processed. *if applicable

- If the client lacks capacity to sign, a legally authorized person may sign and date the form.

» » » Please indicate your legal authority and include documentation of your relationship:

☐ Power of Attorney/Health Care Proxy ☐ Legal Guardian or Conservator ☐ Other, Specify: __________

FEES*: Fees are authorized annually by state law. Fees must be paid before records can be released. Record fees will be billed as follows:

*Cash or credit only

Paper Copies: Maryland: 76¢/page
Virginia: 50¢/page for first 50 pages; 25¢/page at 51 or more pages
Both: Copies totaling less than 20 pages are free

Electronic Copies: Cost of Labor: $40/hr

JSSA, employees, volunteers, and agents have a duty to maintain confidentiality of any protected health information disclosed to them pursuant to this authorization. The client or authorized person may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by providing written notice to JSSA's Compliance Officer. Unless otherwise noted below, this authorization will expire 12 months from the date of consent. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state confidentiality laws, including HIPAA. JSSA may not condition treatment, payment, enrollment, or eligibility for services on whether the client signs this authorization. The client has a right to a signed copy of this authorization.

Printed Name of Person Signing (if not the client): ______________________ Relationship to Client: __________

Signature of Client or Authorized Representative: ______________________ Date Signed: __________

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