

AUTHORIZATION FOR RELEASE OF INFORMATION



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: _____

Previous Names: _____

RELEASE OF INFORMATION ☐ To ☐ From (check all that apply)

JSSA CONTACT INFORMATION

Attention to: _____

Address: _____

Phone/Fax: _____

EXTERNAL CONTACT INFORMATION

Name/Facility: _____

Address: _____

Phone/Fax: _____

I AM REQUESTING RECORDS AND/OR DISCLOSURE FOR THE FOLLOWING DATES:

From: _____ To: _____
Only information obtained during the date range provided above will be disclosed.

PURPOSE OF DISCLOSURE: (check all that apply)

- | | | |
|--|--|---|
| ☐ Coordination of Care | ☐ Personal Records | ☐ Disability Determination |
| ☐ Transfer of Care/New Provider | ☐ Legal/Court Hearing | ☐ Confirmation of Services |
| ☐ Guardianship Process | ☐ IEP/School | ☐ Workers Compensation |
| ☐ Insurance/Billing/TPO | ☐ Other: _____ | |

INFORMATION TO BE RELEASED: (check all that apply)

Instructions: Items listed below with an * are NOT included in "All Records". If the items with an * are being requested, please specifically check those boxes. Substance use disorder-related information may be subject to additional federal confidentiality protections under 42 CFR Part 2.

- | | | |
|--|---|---|
| ☐ Clinical/Mental Health Progress Notes | ☐ Psychiatric Progress Notes | ☐ Case Management Progress Notes |
| ☐ Prescription Record | ☐ Diagnosis | ☐ Evaluation/Assessment |
| ☐ Intake/Closing Summary | ☐ Treatment Plan/Summary | ☐ Billing/Financial Records* |
| ☐ Employment Information | ☐ Letter/Summary of Services* | ☐ Completion of External Form* |
| ☐ Third Party Documentation* | ☐ Medical/Dental Information | ☐ HIV/AIDS Information* |
| ☐ Substance Abuse and/or Alcohol Treatment Records* | ☐ Sexual Abuse/Assault Counseling Records* | ☐ All Records |
| ☐ Other: _____ | | ☐ Please see instructions above. |

_____ signer must initial

FORMAT OF RECORDS TO BE RELEASED:
(check all that apply)

☐
Paper/Hard Copy

☐
Electronic/Email*

email address required

☐
Verbal

☐
Other:

*Email address must be verified before any information can be emailed. All information sent via email will go through our secure email system.

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

Clients and Service Providers:	Paper Copies: 76¢/page
	Electronic Copies: \$6.50
	Both: Copies totalling less than 20 pages are free.
Attorneys/Insurance Companies/Other:	\$22.88 Service Fee in addition to costs stated above

*Cash or credit only

MINOR CONSENT: Please review the information carefully.

- *if applicable
- ☐
MD

A minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic [Md. Code Ann., Health-Gen. II § 20-104(a)]. **Some exceptions may apply*
 - ☐
VA

A minor who is 14 years old or older is “deemed an adult for the purpose of consenting to...medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance;” and the minor is “also deemed an adult for the purposes of accessing or authorizing disclosure” of those records [Virginia §54.1-2969, E and 12 VAC 35-115-90].

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

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 restrictions on further use or re-disclosure under applicable federal and/or state confidentiality laws, including 42 CFR Part 2 and 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.

Consent is granted:
(check only one)

☐
One-Time

☐
One-Year

☐
Other, specify

Cannot exceed 1 year

Signature of Client or Authorized Representative:
Date Signed:

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

* Documentation of legal authority must be included with this request or it cannot be fulfilled.

Office Use Only