Jerry Franklin Counseling

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Release of Information

I hereby authorize Jerry Franklin, MA, LPC to:

- ☐ Release information to:
- ☐ Obtain information from:
- ☐ Exchange information with:

Name: _____
Address: _____
_____
_____
Phone: _____

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Education
- ☐ HIV/AIDS
- ☐ Sexually transmitted diseases
- ☐ Drug or alcohol abuse

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my record may contain information concerning my psychiatric, psychological, drug or alcohol use, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that I may revoke this authorization at any time upon written notice to Jerry Franklin Counseling. I acknowledge that such revocation will not be effective if Jerry Franklin Counseling has already acted in reliance upon this authorization.

This authorization is valid (if not previously revoked) and this consent will terminate upon 90 days from the date of signature of this form, or the following event/condition: _____, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

_____ _____
Client's Name (Print) Date of Birth

_____ _____
Client's Signature Today's Date

_____ _____
Guardian's Signature (if client is a minor) Today's Date