Phoebe Jeffrey's
PSYCHOTHERAPY CENTER

1924 Route 35, Suite 9A
Wall, NJ 07719
(732) 359-8686
Fax (732) 359-8688

Informed Consent of Protected Health Information

Client Information

Last Name: _____ First Name: _____ MI ____

DOB: _____/_____/_____

Address: _____

Phone Number: _____ Cell Number: _____

I, _____ do hereby authorize Phoebe Jeffrey, MA, LPC to release/obtain a copy of my mental health information to the person/facility below:

Name of person/facility to receive information: _____

Address:_____

Phone number: _____

Date of Authorization: ____/____/_____

Authorization to expire on ____/____/_____ or upon the happening of the following event:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Information to be Released *(Note: requests for release of psychotherapy notes cannot be combined with any other type of request.)*

☐ Mental Health Consults/Evaluations

☐ Only those portions pertaining to: _____
(specify provider name and/or dates of treatment)

☐ Authorization for Psychotherapy Notes ONLY

☐ Other: _____

Purpose of Release of Information

☐ Further mental health care
☐ At the request of the individual
☐ Disability determination
☐ Case management
☐ Legal Investigation
☐ Other: _____

Authorization and Signatures

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature Date

_____
(If minor child) Signature of Parent/Guardian

_____
Relationship to Client