RELEASE OF INFORMATION

TJocelyne Counseling & Consulting LLC.

425 Pleasant Street First Floor, Brockton, MA 02301

Phone: 5085800364 Fax: 8885066021

Client's Name:_____**DOB:**_____ **SS#**_____

I authorize the release of my complete health record with the ***exception*** of the following information To or From:

□ *Mental health records* □ *Communicable diseases (including HIV and AIDS)*

□ *Alcohol/drug abuse treatment*

□ *Other (please specify):* _____

Organization/Name:_____

Address:_____

Phone:_____Cell _____Fax_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. Signature of patient or personal representative Printed name of patient or personal representative and his or her relationship to patient.

Client's/Guardian's Signature:_____Date:_____

Jocelyne Counseling & Consulting LLC.'s Representative:_____Date:_____

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