

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient: _____

Date: _____

Date of Birth: _____

I, _____, (hereinafter "Patient") hereby authorize **The Gem Counseling, LLC** (hereinafter "Gem") and **SAMANTHA JEFFERSON** (hereinafter "Provider") to release and disclose mental health treatment information and record(s) obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis, history, mental illness, and treatment to:

Name: _____

Address: _____

Relationship to Patient: _____

Phone Number: _____

Email: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when permitted by law. I understand that I have a right to receive a copy of this authorization. I understand that Provider shall not condition my treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance upon it. Such revocation must be in writing and signed by me, the Patient and delivered via email to Provider at SUPPORT@THEGEMCOUNSELING.COM to be effective.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state law may protect such information.

The authorization will expire twelve (12) months from the date of my signature, unless revoked prior to that date.

Patient's signature: _____

Date: _____

Printed Name: _____

IF TO PATIENT UNDER THE AGE OF 18 AT THE TIME OF AUTHORIZATION

Minor's Parent/Guardian: _____

Date: _____

Printed Name: _____
Relationship to Patient: _____