JILL SMITH + associates

COUNSELING • COACHING • CHANGE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby authorize Jill Smith, Julie Lundy or Laura Truesdale to use or disclose my protected health information as outlined below. I understand that the information I authorized may be re-disclosed and no longer protected by state and federal regulations.

This authorization is subject to cancellation at any time by the patient, provided that the cancellation is made in writing, except to the extent those involved have already acted on your request prior to receiving the cancellation request.

Patient Name: _____ DOB:_____

Address:_____

City,State,Zip:_____

Primary Phone: (_____)_____-_____

Purpose of Disclosure:_____

_____

What information is being released: _____

_____

_____ _____

Signature of Patient, or Parent if Patient is a Minor Date

Name of Person(s), Medical Office, Facility, and/or School to release information to and receive information from Jill Smith & Associates.

_____Phone:_____

_____Phone:_____

_____Phone:_____