John F. Kennedy Behavioral Health Center

Release of Information

I _____ _____
Print Name DOB

_____
Print Street Address City State Zip Code

give my permission to **(JFK)** to release the following specific information on **me** or **my child,**
Circle One

_____.
Print child's name if under 14 years of age (MH only)

Type of information to be released: Client must initial all that applies

_____ Psychiatric Evaluation/CBE/CBR _____Therapist Notes _____ Doctor Notes

_____ Medication Order Sheets _____Treatment Plans _____ Intake Documentation

_____ Discharge Documentation ☑ Other (Specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

_____

Requested dates of treatment _____ _____
From **To**

To the following: RECORDS DEPOSITION SERVICE, INC.
Print Name of Institution or Intended Person(s)

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337
Print Address

The purpose of this authorization is LITIGATION / DISCOVERY BEFORE TRIAL
Specify

Note: The purpose for disclosure or release is at the request of the Individual.

This consent shall be in effect from _____ to _____.
Date **Date** (Not more than 1 yr.)

Client must initial the following:

_____ I (we) understand that this authorization is voluntary and that my treatment, payment for services, enrollment, or eligibility for benefits will not be affected if I do not sign this form.

_____ I will be told the name, address and the date when the information will be sent.

_____ I have the right to revoke consent at any time by written or verbal request to my therapist, case manager or doctor unless the disclosure has already been made. If a verbal request is made, the staff is responsible to put such request in writing.

_____ Within 5 days of the date of this authorization, I have the right to inspect all information to be released. After such time, my information will be automatically sent out.

_____ I understand that information from sources other than JFK will not be released.

_____ I understand that there is a potential for the released information to be redisclosed by the recipient.

_____ I consent to release and disclosure of my confidential Drug & Alcohol related information.

_____ I have **accepted / declined** a copy of this form.
Circle One

Please initial or mark N/A if not applicable:

_____ I consent to disclosure of my treatment summary if any, in relation to my drug, alcohol abuse or dependency to medical personnel, government officials, judges and probation/parole officers and 3rd party payors. This is pursuant to 4 PA Code § 255.5.

_____ I consent to release and disclosure of my Confidential HIV - related information.

_____
Print Client Name

_____ _____
Signature of Client Date

_____
Print Name of Parent/Guardian of Child under 14 years of age (MH only)

_____ _____
Signature of Parent/Guardian of Child under 14 years of age (MH only) Date

_____ _____
Print Witness Name Date

_____ _____
Witness Signature Unit/Title

This information complies and remains in accordance with the Health Insurance Portability and Accountability Act of 1996.

Revised October 2011