**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**
**INSIGHT COUNSELING ON BEHALF OF JONATHAN SPEARE, Ph.D. LICENSED PSYCHOLOGIST**

Instructions to client or legally responsible other: 1. **Make sure ALL applicable blanks on this form are filled in.** 2. Sign only if you believe the release is in YOUR best interest. 3. We will not condition treatment on the completion of this authorization. 4. **Please read the "Revocation and Expiration of Consent" section on this form in its entirety before signing.**

CLIENT NAME:_____ BIRTH DATE:_____

*Any previous name(s)*_____

ADDRESS:_____ PHONE: _____

I hereby authorize Insight Counseling on behalf of Jonathan Speare, Ph.D., Licensed Psychologist to _____**disclose to**

_____

Organization(s) or person(s) Relationship to client

Address:_____

**(Release may be in person, by mail, by telephone or by facsimile, unless otherwise stated.)**

**THE FOLLOWING INFORMATION:** ____Discharge/treatment summary ____Diagnosis

**____ALL past, current and future information and/or services provided during the period of: From _____ To Current**

*If more information is needed after receiving discharge/treatment summary, a more detailed release of information is* ***required*** *to be completed.*

**This may include** reports involving HIV (human immunodeficiency virus), AIDS, ARC (AIDS related complex), alcohol/drug abuse or dependency, psychiatric treatment, sickle cell anemia or tuberculosis.

**THE PURPOSE FOR DISCLOSURE IS:** ____ Continuing care ____ Treatment planning ____ Evaluation

_____ Social Service/Court involvement

_____ Other (specify) _____

**REVOCATION AND EXPIRATION OF CONSENT:**

Upon fulfillment of the above stated purpose(s), **this consent will automatically expire one year following the date of signature(s)** without my express revocation, ***unless an earlier date or event is otherwise specified*** _____. I understand that I may revoke this consent to release information at any time by written notice, except when legal action prevents revocation (probation, parole, court confinement) or when I have specifically waived in writing my right to revoke this release. However, any release made in good faith, prior to receipt of revocation, shall be deemed valid. A photocopy of this authorization may be treated in the same manner as the original. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal and state privacy regulations, the information described above **may be disclosed and no longer protected by those regulations**. I understand that if this information is scanned into an electronic health records system (or other computerized storage), this office has no control over who may gain access to it, so **my privacy and confidentiality may be compromised.** I understand that I may inspect and have a copy of the health information described in this authorization, and that I may receive a copy of this form if I request it.

**PAYMENT FOR COPIES OF RECORDS:** By my signature below I hereby authorize Insight Counseling on behalf of Jonathan Speare, Ph.D., L.P. to bill and receive payment for any charges incurring in providing copies of my records to the organization (s) or person (s) listed above.

***By my signature below, I confirm that I understand the nature and purpose of this release.***

_____ _____

Client's Signature Signature of Parent/Guardian

_____ _____

Date Relationship to Client

_____ _____

***Witness signature is required if not signed at Insight Counseling on behalf of Speare Psychological Services*** Reason for acting on client's behalf

If a client is unable to sign, the person signing the authorization will be required to show proof of guardianship, or other authority and relationship to client allowing him/her to authorize the release of information. 08/2022