**Jacqueline L. Berg, MA, LMFT**
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## Authorization for Release of Protected Health Information

Client Name: _____ Date of Birth_____

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Client Name: _____ Date of Birth_____

I authorize Jacqueline L. Berg and _____
to disclose, discuss and exchange confidential information regarding the above listed individual.

**Initial all types of information to be disclosed between above parties:**

___ Treatment Verification
____ Treatment Dates ____ Discharge Status
___ Referral/Intake Information
___ Assessment Report/s
___ Psychological or Psychiatric Evaluation Report/s
___ Academic or Educational Records and/or Reports
___ Contact Notes/Reports
___ Billing Records
___ Discharge reports
___ Treatment Plan/s
___ Service Extension Reports
___ HIV-related information contained within records will be released unless otherwise indicated here. Do not release this information ____.
___ Drug and alcohol information contained within records will be released unless otherwise indicated here. Do not release this information ____.
___ Other (specify): _____
___ Other (specify): _____
___ Other (specify): _____

The purpose of the disclosures authorized by this consent is for:
___ Treatment Coordination and/or providing ongoing services
___ Other (specify): _____

(OVER)

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances as described in Jacqueline L. Berg's Consent for Services document.
- Federal confidentiality regulations (42 CFS Part 2) prohibit redisclosure of information from alcohol and drug abuse client records. However, the HIPAA requires Jacqueline L. Berg to notify me of the potential that information disclosed as a result of this information might be redisclosed by the recipient and is no longer protected by the HIPAA rules.
- I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- This authorization will expire in one year from the date I sign it or on _____. I can revoke this authorization at any time, except to the extent that information has already been released as a result of this authorization. To revoke this authorization, written notice must be presented to Jacqueline L. Berg, 36 Country Club Road, Unit 823, Gilford, NH 03249.
- Communications resulting from this authorization will reveal that I received services from Jacqueline L. Berg.
- Treatment will not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR §164.508(b)(4)(iii)].

I have read this Authorization for Release of Protected Health Information and understand its contents:

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (when required) Date

_____ _____
Witness Signature Date