Jennifer K. Coleman, Ph.D.
Licensed Psychologist
Coleman Child and Family Services, PA
2460 Delaney Avenue
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Phone (910) 202-9113 Fax (910) 202-9289

AUTHORIZATION FOR USE/RELEASE OF PROTECTED HEALTH INFORMATION

I, ____, authorize Jennifer K. Coleman of Coleman Child and Family Services, PA to:

Release ____________ (please initial) **Mutually Exchange** ___________ (please initial)

Individually identifiable confidential mental health information as described below:

Name/Agency: ____

Phone/Fax: ____Covering the period: _____________

Client's Name ____ Date of Birth ________________

Information to be shared for purposes of: ____

Content of Information to be shared (please initial):

______ Psychological information – evaluation summary, treatment plans, formal testing and assessment
______ Educational records – academic and behavioral, to include completion of rating scales
______ Medical and medication information – to include psychiatric treatment
______ Family and social information
______ Substance use or abuse information
______ HIV/AIDS information

I understand that the shared information is intended to be used for specific purposes related to psychological services for my child. Those purposes can include determination of insurance benefits, support for the development of appropriate treatment goals, coordination of services between treatment providers, and/or advocacy on behalf of myself or my child.

I understand that Dr. Coleman may not condition my or my child's psychological treatment on my refusal to sign this authorization. Signing this form indicates authorization for this information to be exchanged or released by phone, the US Postal Service, fax, or e-mail.

I may revoke this request at any time except to the extent that action based on this request has been taken. This request will automatically expire 12 months after the day it is signed. I release Jennifer Coleman, PhD and her staff from any liability connect with the use of these records, or the information in them, by anyone outside of Dr. Coleman's office. I understand that I have the right to seek assurances from the persons/organizations authorized to receive this information that they will not redisclose this information to any other party without my further authorization.

This authorization is fully understood and is made voluntarily on my part, on behalf of myself or my child.

_______________________________________ ____________________ ____________

Signature of Responsible Party Relationship to Client Date

This authorization form implements the requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R., Parts 160, 184), the federal drug and alcohol confidentiality law (43 C.F.R., Part 2), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).