Shanna D. Jackson, PhD, LPC, CPCS
Licensed Clinical Psychologist

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Authorization to Release Information

I authorize my psychotherapist, Shanna D. Jackson, to release and to receive the following information:

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This information should only be released to and received from:

____

I am requesting my psychotherapist to release and to receive this information for the following reasons: ("At the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose)

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This authorization shall remain in effect until (fill in expiration date or an event that relates to the individual or the purpose of the use or disclosure)

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You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychotherapist generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

______________________________   ______________________________
Signature of Client   Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.