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**AUTHORIZATION FOR USE AND DISCLOSURE
 OF PROTECTED HEALTH INFORMATION**

Client: _____ Date of Birth: _____

I hereby authorize Jennifer Jencks, LICSW, to release/obtain information:

Regarding: Presence in treatment, progress in treatment, diagnosis, labs,

For the purpose of: Facilitating treatment, _____

To/From: _____

Phone: _____ Fax: _____

I understand that the information in the health record may relate to treatment for alcohol or drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to Jennifer Jencks, LICSW at the above noted address. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless earlier revoked in writing, this authorization will expire 12 months after the date it was signed.

I understand that signing this authorization is voluntary and that Jennifer Jencks, LICSW, will, if legally required, provide treatment and pursue payment for services regardless of whether I sign this authorization. If, however, my treatment is related to a research study, or solely for the purposes of providing information about my health or medical condition to someone else, Jennifer Jencks, LICSW, may require that I sign this authorization before providing treatment to me.

I understand that if I authorize Jennifer Jencks, LICSW, to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Jennifer Jencks, LICSW, may no longer be protected by the federal rule on the privacy of medical records.

 Signature of Client/Guardian

 Date

 Witness

 Date

 Signature of Client Under 18