RELEASE OF INFORMATION

Patient Name: _____

SSN: _____ DOB: _____

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to any licensed provider employed by Gabriele Jones, PhD, PA.

I authorize the exchange of information between the following:

Information to be released **from/to**:

_____

_____

_____

Information to be released **to/from**:

Gabriele Jones, PhD, PA
75 Trotter Hills Circle, PO Box 4600
Pinehurst, NC 28374
Phone: 910.255.1000
Fax: 910.255.1045

Purpose of Release:

____ Continuity of Care ____ Insurance ____ Other
____ Legal Representation ____ Request of the Individual _____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I understand that information may be shared in writing, via email, in electronic form and/or in meetings or by telephone. This release will automatically expire 12 months from the date of signature.

I understand that I can withdraw this consent at any time by submitted a written revocation to Gabriele Jones, PhD, PA. The revocation will not apply to information that has already been released.

I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then no longer be protected under the HIPAA Privacy Rule.

_____ _____
Patient signature Date

_____ _____
Patient Parent/Guardian signature Relationship to patient

Witness _____

Rescind Consent: I hereby rescind the prior consent granted to Gabriele Jones, PhD, PA, to release and/or discuss any information with the individuals(s)/agencies listed above.

Signature: _____ Date: _____