*Jennifer M. Shuart, LICSW, PMHNP-BC, APRN*

*Stepping Stones to Well Being, LLC*

It is required by law to obtain written permission to release your medical information

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request and authorize Stepping Stones to Well-Being, LLC to

Exchange With Receive From Provide to/with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name and Address of the Agency/Person)

The purpose of this release is for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released in written or oral form (Please Check):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Initial Evaluation |  | Medical History |
|  | Recent Lab Work |  | Treatment Summary |
|  | Diagnosis |  | Current Medications |
|  | Hospital Discharge Summary |  | Psychological Testing |
|  | IEP/504 Plan |  | Appointment Times/Attendance |
|  | Other |  | Other |

If my initials appear here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I specifically authorize release of drug, alcohol abuse, sexually transmitted disease and/or counseling/psychiatric records. I understand that my drug treatment records are protected by under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Subpart C and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

If my initials appear here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I specifically authorize release of my records that contain information about my HIV diagnosis, tests or treatment of HIV and AIDS, and which may contain reference to my identity as HIV positive or as an AIDS patient.

I have carefully read and understand the above statements, and voluntarily consent to disclosure of the above information about, or medical records of my condition to those persons of agencies named above. I understand this authorization may be revoked at any time. Revocation must be made in writing.

This authorization will expire at the termination of treatment unless revoked prior to termination of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Jennifer M. Shuart, LICSW, PMHNP-BC, APRN Date