**West Vernon Center**
**Raleigh Psychological Associates**
**122 West Vernon Ave**
**Wake Forest, NC 27587**

## CONSENT FOR THE RELEASE AND/OR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of patient, student or client: _____ DOB: _____

**I authorize**_____ to release_____ any and all information necessary to
*(Jackelin J. Veloz-Jefferson, Ed.S., LPA, HSP-P)* *Initial above*

**Who should receive information?** _____
(Dr. or agency that should receive records; specify address or fax number)

**ADDITIONALLY**, *for the exchange of protected information*:

**I authorize**_____ to release _____ any and all information necessary to
(FROM) *Initial above*

**Entity to receive information**: _____
*(Jackelin J. Veloz-Jefferson, Ed.S., LPA, HSP-P)*

**Via**_____ Any appropriate modality, or only____ Phone/face-to-face, ____ facsimile, _____ mail, _____ E-mail

Information specified below if "**any and all necessary**" was **not** initialed above:

____ Financial, billing, claims, attendance, and billing
____ Medical and health issues
____ Reports and data from psychological testing
____ Educational / academic
____ Summary report of diagnostic assessment, recommendations, and treatment progress
____ Substance or Alcohol use
____ Sexual Abuse
____ HIV/AIDS information
____ Other (specify):

I request that specified information be released or exchanged for the **purpose(s)** checked below:

____ At my request
____ To facilitate assessment and treatment
____ To facilitate collaboration
____ Other:

By signing, I authorize and agree to the actions specified above. I understand that I have the right to revoke this authorization at any time by notifying the parties specified above in writing, except that revocation will not be effective to the extent that action has already been taken on the authorization or if this authorization was provided as a condition of obtaining insurance coverage or reimbursement and the insurer has a right to contest a claim, or if court-ordered. I understand that information used or disclosed pursuant to the authorization is beyond the control of the professionals specified, and consequently may be subjected to re-disclosure by the recipient and no longer protected by the HIPAA. Protection of confidentiality of substance abuse information per stature 42CFR part 2 and protection of HIV/AIDS information under general stature 130A-143 will be adhered to by this office. I authorize use of a copy, including an electronic copy of this form, to authorize the disclosure of the information requested. I release and discharge the parties specified above, their owners and staff, and business partners/associated from any and all liability, cost and claims arising from the release of this information. I will pay any reasonable administrative costs charged by the professionals parties incurred in responding to this request. If not revoked earlier, **this authorization expires automatically within one year from the date it is signed or upon revocation.**

Signature: _____ ___ Check if signed by an adult patient
___ Check if signed by the parent of a patient who is a minor

Date Signed: _____ If signed by parent, print parent's name: _____

Witness: _____
(Adult witness' printed name and phone number (if not signed in Jackelin Veloz-Jefferson, Ed.S., LPA, HSP-P office)

90-411 Record copy fee. A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying and mailing medical records. The maximum fee for each request shall be 75 cents per page for the 25 pages, 50 cents per page for pages 26 through 100, and 25 cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of $10.00, inclusive of copying costs. Fee may not exceed $100.00.