Authorization for Release & Mutual Exchange of Information

All clinical and demographic information are held strictly confidential and cannot be released from JNG Health Network without written consent, or unless mandated by law and statutes.

☐ **Authorization for Release of Information:**

I, ___________________________, whose date of birth is ________________ hereby request and authorize JNG Health Network to release the following information from my clinical records or from the clinical records of my Minor Child whose name is _________________________________ to:

____

____

Person/Company Name, Address, Phone, Fax, Email

☐ **Mutual Exchange of Information:**

To enhance the effectiveness of the services provided to me, I ___________________________, whose date of birth is ________________ hereby request and authorize the Mutual Exchange of my Protected Health Information or that of Minor Child whose name is _________________________________ between:

Name of Entity:	JNG Health Network	
Address:	1133 SW 167 Ave. Pembroke Pines, FL 33027	
Phone:	305-724-8040 or 954-404-7052	
Fax:	954-435-5982	
Email:	jnghealth@comcast.net	

For services rendered during this specific time frame: From_____________________ to ____________________

Type of Information to be Released and/or Exchange:

☐ Psychological Assessment ☐ Treatment Participation Record
☐ Treatment Progress Summary ☐ Other____
☐ Protected Health Information, i.e. Illicit Substance Use or HIV-AIDS Health Status

For the purpose of:

☐ Continuity of Care ☐ Court/Legal Proceedings ☐ Quality Assurance
☐ Case Management ☐ Personal Interest ☐ Other_______________________________

Release in the form of: ☐ Audio ☐ Verbal ☐ Written ☐ Fax ☐ E-mail ☐ Other___________________________

I understand this authorization will remain in effect for the time frame indicated unless I specify an earlier expiration date:

☐ Ninety (90) days ☐ Six (6) months ☐ One (1) year ☐ Specific expiration date: _________________

I understand that unless otherwise limited by state or federal regulations, I may withdraw this consent at any time.

Client Signature & Date: ____

Parent/Legal Representative Signature & Date: ____

Witness Signature & Date: ____