

Authorization Form

Megan A. Jankord, MA, LMFT
Parkdale Therapy Group, LLC
1000 Shelard Parkway, Suite 520
St. Louis Park, MN 55426-1053
952-224-0399, Fax 952-224-0396

This form when completed and signed by you, authorizes me to exchange/gather protected health information for your clinical record with/and/or by the person(s) you designate.

I _____ DOB (MM/DD/YYYY) _____
authorize Megan A. Jankord, MA, LMFT and/or his or her administrative and clinical staff (cross out if not applicable), to request/release/exchange this information:

<input type="checkbox"/> Initial Assessment/History	<input type="checkbox"/> Psychological Testing, Evaluation & Treatment Plan
<input type="checkbox"/> Past and Ongoing Case notes	<input type="checkbox"/> Chemical Dependency Evaluation & Treatment Plan
<input type="checkbox"/> Summary of Treatment	<input type="checkbox"/> Neurological Testing, Evaluation & Treatment Plan
<input type="checkbox"/> Medical/Lab Results	<input type="checkbox"/> Educational Assessments, Evaluation & Treatment Plan
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Legal/Police/Criminal Records
<input type="checkbox"/> All of the above	
<input type="checkbox"/> Other (specify) _____	

(Description of the information you want disclosed should be as specific and detailed as possible.)

This information should only be requested/released/exchanged to or with:

_____ (Individual(s)/Clinic)
_____ (Address)
_____ (Phone/Fax)

I am requesting my counselor to release/exchange this information for the following reasons: (“at the request of the individual” is all that is required if you are my client and you do not desire to state a specific purpose.)

At the request of the individuals

This authorization **will automatically expire one year after the signing of this form**, unless indicated otherwise below:

<input type="checkbox"/> 30 days after last date of service	<input type="checkbox"/> Immediately after requested information is received
<input type="checkbox"/> Upon my written request	<input type="checkbox"/> Other (Specify) _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have acted in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

Signature of Client

Date

Signature of Client

Date