KRISTIE JEWITT MS, LMFT

Release of Information

CLIENT NAME	DATE OF BIRTH

I authorize that the requested information may be:	
☐ Released To ☐ Received From	
NAME OF PERSON/PROVIDER/AGENCY	**CONTACT NAME**
STREET ADDRESS	**CITY, STATE, ZIP**
PHONE NUMBER	**FAX**

I authorize that the requested information may be:	
☐ Released To ☐ Received From	
NAME OF PERSON/PROVIDER/AGENCY	**CONTACT NAME**
Kristie Jewitt, MS, LMFT, PLLC	Kristie Jewitt
STREET ADDRESS	**CITY, STATE, ZIP**
130 Allens Creek Rd	Rochester, NY, 14618
PHONE NUMBER	**FAX**
(585) 244-4161 Ext. 6	

PURPOSE OF THIS REQUEST (CHECK ONE)		
☐ Healthcare	☐ Insurance Coverage	☐ Healthcare
☐ Discharge Planning	☐ Personal	☐ Other:

SPECIFIC INFORMATION AUTHORIZED (SELECT ONE OR MORE AS APPROPRIATE)		
☐ Assessments	☐ Progress Notes	☐ Laboratory Test Results:
☐ Diagnostic Impression	☐ Discharge Summary	☐ Diagnostic Test Results:

☐ Treatment Plans	☐ Education Information	☐ Other:
☐ Treatment Summary (including history/physical, laboratory tests & x-ray reports)		
☐ Entire copy of the inpatient/outpatient record checked above		

ONE-TIME USE/DISCLOSURE		
I authorize the one-time use or disclosure of the information described above to the person/provider/agency identified. My authorization will expire:		
☐ When the requested information has been sent/received	☐ 90 Days from This Date	☐ Other:

PERIODIC USE/DISCLOSURE		
I authorize the periodic use/disclosure of the information described above to the person/provider/agency identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:		
☐ When I am no longer receiving services from Kristie Jewitt, MS, LMFT	☐ One Year from This Date	☐ Other:

I UNDERSTAND

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a **written** request to the Strong Health Program address above, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization.
- If the medical record information is not sent to another care provider there may be a charge for the requested records.

CLIENT SIGNATURE (OR GUARDIAN IF UNDER 18)	DATE
WITNESS	**DATE**