Jes James Sellers, PhD, Psychologist
2460 Fairmount Blvd., Suite 301
Cleveland Heights, Ohio 44106
drjessellers@gmail.com

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____ _____ _____

Address _____

City: _____ State: _____ Zip: _____

Phone/Cell _____ Date of Request _____ _____ _____

The individual noted above has authorized the transmission of information to Dr. Jes Sellers from the following individual or organization:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone _____

The type and amount of information to be used or disclosed is as follows:

_____ Mental Health / Psychotherapy Records
_____ Psychiatric Assessment / Diagnosis
_____ Treatment Summary
_____ Prescription Medication Summary
_____ Psychological Testing Assessment
_____ Other (specify):

_____

1. I understand that the information in my health & counseling record may include information relating to sexually transmitted disease, behavioral or mental health services and/or treatment for alcohol and/or other drug abuse.

2. This information should be disclosed to Dr. Sellers for the purpose of assisting him in my mental health care.

3. I understand that I have a right to revoke this authorization at any time and that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Sellers. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

If I fail to specify an expiration date, event or condition, this authorization will expire in **180 days**. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can consult with Dr. Sellers.

_____

Signature of patient or legal representative Date

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.