Marni L. Jacob, Ph.D., LLC
Licensed Psychologist
1200 N. Federal Highway, Suite 200
Boca Raton, FL 33432
(561) 325-5115

Authorization to Obtain and/or Release Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

I, _____, authorize

Marni L. Jacob, Ph.D., LLC

To _____ OBTAIN and/or _____ RELEASE protected health information concerning the patient named above to/from the following:

_____

_____

_____

_____

I specifically authorize the use and disclosure of the following PHI:

_____ ALL information and records

Only the following:

_____ Intake Evaluation
_____ Diagnosis/Diagnoses
_____ Treatment Summary
_____ Statements of Progress
_____ Recommendations
_____ Other: _____

Purpose of disclosure: _____

By signing this form, I understand that I am authorizing the use and/or disclosure of my protected health information as defined under the federal regulations implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that there is a potential that the PHI may be re-disclosed by the recipient and no longer protected by federal or state privacy laws. I understand that I may revoke this consent, in writing, at any time, except to the extent that action has already been taken. Unless otherwise specified herein, this authorization will expire one year from the date of initiation.

Please mail any requested information to:
Marni L. Jacob, Ph.D., LLC, 1200 N. Federal Highway, Suite 200, Boca Raton, FL 33432

Signature of Patient or Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Revised 5.5.15