Jacob Center for Evidence-Based Treatment
7900 N. Federal Highway, Suite 615
Boca Raton, FL 33434
Phone: (561) 290-9080
Fax: (561) 705-0895
www.jacobcenterforebt.com
info@jacobcenterforebt.com

Authorization to Obtain and/or Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Name of Person Completing this Form (if different than patient): _____

Relation of Person Completing Form: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other

I authorize the **Jacob Center for Evidence-Based Treatment** to:

_____ OBTAIN AND RELEASE, _____ OBTAIN, or _____ RELEASE protected health information concerning the patient named above to/from the following person, provider, or treatment facility:

_____

_____

_____

_____

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:
Jacob Center for Evidence-Based Treatment, 7900 Glades Road, Suite 615, Boca Raton, FL 33434

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

Signature of Witness: _____ Date: _____

Revised 9.13.2022