Jacob Center for Evidence-Based Treatment
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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:

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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 1.27.2023