# RELEASE OF INFORMATION

Jennifer D. Vann, MS, LMFT
*Cornerstone Family Services, LLC*
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*** This form must be completed in full in order to be valid***

Client's name _____ Date of Birth _____

I hereby request and authorize Jennifer D. Vann, MS, LMFT :

□ To Release To _____ (Must be an individual's name. No Organizations)

Address _____

_____

Phone _____

Fax _____

□ To Request From _____

Address _____

_____

Phone _____

Fax _____

**The following information:**

□ Psychiatric Evaluation □ Social History

□ Laboratory Reports □ Care Plan

□ Summary of Treatment □ Attendance

□ Clinical Assessment

□ School Information

□ Other (please describe) _____

_____

_____

**For the purpose of**: □ Coordination of Treatment □ Other _____

*Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Jennifer D. Vann, MS, LMFT disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law. Please note that once information has been released to the designated party Jennifer D. Vann, MS, LMFT nor Cornerstone Family Services, LLC are liable for the misuse of information by that party.*

After giving due consideration to the above statement, I authorize Jennifer D. Vann, MS, LMFT to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Jennifer D. Vann, MS, LMFT and Cornerstone Family Services, LLC from all liability that may arise from the release of the information herein requested.

☐ **By checking this box I agree that information may be shared electronically with other professionals via email. I understand that the security of email servers can not be guaranteed and I accept the risk associated with electronic transfer of information.**

I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has been taken in reliance and is only valid for a period of 1 year from the date of my signature unless I specify another date or event here:

_____.

_____ _____

Patient/Parent/Legal Guardian Signature Date