JASON T. CERRO LPC, INC.

3175 Gold Star Highway

Unit 104, G3

Mystic, CT 06355

help@jasontcerro.com

401-524-5938

Authorization for use of Protected Health Information

Client: _____

DOB:_____

1. I authorize JASON T. CERRO LPC, INC. to disclose/obtain my health information to/from:

_____

2. For the following date or time period: Unless sooner revoked, this consent expires 365 days from the date signed below.

3. The purpose of this disclosure/obtainment of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, to coordinate treatment services. If other purpose please specify:

_____

3. Information to be disclosed/obtained:

___Assessment ___Medical Information ___Treatment Plan or Summary

___Diagnosis ___Discharge/Transfer Summary ___Progress in Treatment

___Psychosocial Evaluation ___Continuing Care Plan ___Psychiatric Information

___School Performance ___Other (Please specify)_____

I understand that the information in the health record may relate to treatment for alcohol or drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to Jason T Cerro, LPC . I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that signing this authorization is voluntary and that Jason T Cerro, LPC will, if legally required, provide treatment and pursue payment for services regardless of whether I sign this authorization. If, however, my treatment is related to a research study, or solely for the purpose of providing information about my health or medical condition to someone else, Jason T Cerro, LPC may require that I sign this authorization before providing treatment to me.

I understand that if I authorize Jason T Cerro, LPC to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Jason T Cerro, LPC may no longer be protected by the federal rule on the privacy of medical records. I release Jason T Cerro, LPC from any liability that may arise in connection with obtaining and/or disclosing this information, provided that said release of information is done substantially in accordance with applicable law.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure/obtainment of the above information to those persons/agencies named above. A photocopy of this authorization is as valid as the original.

_____ _____ _____

Signature of Client or Authorized Representative Date

_____ _____

Printed Name of Authorized Representative Relationship to Client