CLINICAL INTAKE FORM

INTAKE DATE: _______________ COMPLETED BY: __________________________ EHR ENTRY? ❑

CLIENT LEGAL NAME: ____ DOB: ________________

GENDER: ❑ Male ❑ Female ❑ Transgender ❑ Other __________________________________

OTHER FAMILY MEMBERS (Name, DOB): ____

____

PHONE 1: ___________________ ❑ Home ❑ Mobile PHONE 2: ___________________ ❑ Home ❑ Mobile

ADDRESS: ____

REFERRED BY (Agency, Name): ____

REASON FOR SERVICE: ____

____

____

INSURANCE | PROGRAM INFO

INSURANCE

Insurance Co: ______________________________________ Member ID: ______________________________

Primary Beneficiary (Name, DOB, Address): ____

____

PROGRAM (Check One)

❑ VOCA ❑ DARS ❑ Campus ❑ CPS ❑ Other: __________________________________

Additional Info: ____

SLIDING FEE

Monthly Income: $____ Fee: $________________________

APPOINTMENT INFO

PREFERRED LOCATION: ❑ JFS on Military ❑ MRWCC ❑ First Available

ELIGIBLE COUNSELOR: ____

APPOINTMENT AVAILABILITY: ____

CONTACT NOTES:

Attempts to Contact	Appointments Offered	Outcomes

Therapist Assigned: __________________________________ *Appointment Given:* ______________________

INSURANCE VERIFIED BY: ________________________ DATE VERIFIED: ____________________

CLIENT LEGAL NAME: ____ DOB: ________________

DEDUCTIBLE

Family: $____________________________ Individual: $____________________________

Family Met: $______________________________ Individual Met: $_________________________

Copay: ____ Deductible: ______________________________

Medical Included: ❑ Yes ❑ No

Ins Pays: _________% Allowed Sessions/Year: __________________________

Benefits--S/W:_____________________ IN or OUT

Claims Mailing Address: ____

____

AUTHORIZATION INFORMATION

Authorization Required: ❑ Yes ❑ No Auth Phone #: ______________________________

Representative Name: ____

Authorization Number: ____

Dates: From ___________________ to ___________________ No. of Visits: ____________________

SECONDARY INSURANCE INFO

____

____

____

NOTES: ____

____

____

____

New Client Information

NEW or RETURNING Referred by: ________________________________

Client Name: ____

DOB: ______________________ Age: __________ SSN: ________________________________

Gender: ❑ Male ❑ Female ❑ Transgender ❑ Other ____________________________________

____
Address City Zip County

Phone 1: ___________________ ❑ Home ❑ Mobile Phone 2: ___________________ ❑ Home ❑ Mobile

E-mail: __________________________________ Employer/School: ____________________________

Therapy Seeking: ❑ Individual ❑ Family ❑ Group

Race/Ethnicity: ❑ African American ❑ American Indian ❑ Asian ❑ Hispanic ❑ White ❑ Other: ___________

Religion: ❑ Jewish ❑ N/A ❑ Other: _____________ Language: ❑ English ❑ Spanish ❑ Other: ___________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Living Together

Monthly Income: $ _____________ Yearly Income: $_____________ *(Both income brackets must be filled in).*

PERSONS IN HOUSEHOLD	AGE	GENDER	RELATIONSHIP TO CLIENT

Legal authority to seek treatment for minor: ____

Emergency Contact Information

Name: ____ Relationship: ______________________

Phone Number: ____ ❑ Home ❑ Mobile

PRIMARY INSURANCE INFORMATION: *(All information below can be found on insurance card)*

Ins Co: ____ Ins Ph: ___________________________

Policy Holder's Name:________________________________ Employer: __________________________

Policy Holder's SSN:_____________________________ Policy Holder's DOB: ____________________

Policy Holder's Address:____

ID #:___________________________ Group: __________________________ Eff. Date: _______________

SECONDARY INSURANCE? Yes or No IF YES ASK FOR SECONDARY INSURANCE FORM

Presenting Problem:
____
____
____
____

OFFICE USE ONLY

Brief Service: ____

Condition → Brief Service Case Status → Closed Services → COMP

Entered in EHR? ❑ Staff Initials: __________ Date: ____________

Jewish Family Service
12500 N.W. Military Hwy., Suite 250
San Antonio, TX 78231
210-302-6920 | Fax: 210-302-6952

Mission Reach Wellness & Counseling Center
1151 Mission Road
San Antonio, TX 78210
210-533-1112 | Fax: 210-533-1113

LATE CANCELLATION and NO SHOW POLICY

Your progress is very important to us. For that reason, your appointment time is reserved for you exclusively. If you must cancel, please do so with at least 24 hours' notice. Cancellations made with 24 hours' notice will not be charged a cancellation fee.

If you cancel without sufficient notice OR fail to attend a scheduled appointment, a $30 fee will be charged to your account and due at your next appointment. Appointments can be canceled or rescheduled by calling JFS at 210-302-6920 or MRWCC at 210-533-1112. Voicemails and emails can be left when the office is closed.

If more than three (3) appointments are canceled without sufficient notice OR if you fail to attend three (3) scheduled appointments, your therapist and the Clinical Director may refer you out of the practice. Consistent attendance is one of the cornerstones of success in psychotherapy and we hope you will play an active role in your care.

Client Copy; Please obtain for your personal records.

Jewish Family Service
12500 N.W. Military Hwy., Suite 250
San Antonio, TX 78231
210-302-6920 | Fax: 210-302-6952

Mission Reach Wellness & Counseling Center
1151 Mission Road
San Antonio, TX 78210
210-533-1112 | Fax: 210-533-1113

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

I, ______________________________________ (Client/Legal Representative), have

received a copy of the Jewish Family Service Notice of Privacy Practices.

____

Printed Name of Client

____

Printed Name of Legal Representative (if applicable)

____ ________________

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained.

☐ Individual refused to Sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented obtaining acknowledgement

☐ Other (Please Specify): ____

____

Staff Initials: _________________

Jewish Family Service
12500 N.W. Military Hwy., Ste. 250
San Antonio, TX 78231
210-302-6920 | Fax: 210-302-6952

Mission Reach Wellness & Counseling Center
1151 Mission Road
San Antonio, TX 78210
210-533-1112 | Fax: 210-533-1113

CONSENT FOR TREATMENT

Client Name ______________________ **Therapist** ______________________

Dear Client:

Welcome to Jewish Family Service (JFS). Our goal is to make your counseling experience as productive and beneficial as possible. Psychotherapy is a form of treatment in which you and your therapist form a partnership to help you explore and gain an understanding of your feelings, motivations, thoughts, and behaviors in order to create changes which will enable you to cope better with current and future problems. The following information is about our office and procedures to ensure you receive a positive experience at JFS, as your relationship with us is important.

Clinic and staff policies: JFS clinical staff consists of master-level social workers, counselors, marriage, and family therapists, and master-level and Ph.D.-level interns all of whom are supervised by senior staff. All interns will be identified as such.

The first session or two with your therapist will generally be for evaluating what kind of treatment is best for you. If, at any point in your therapy, the therapist feels that physical, psychological or psychiatric evaluation is necessary for your effective treatment, we reserve the right to make treatment contingent upon you receiving the requested evaluation and follow-up.

JFS reserves the right to refuse treatment to anyone who comes to a session under the influence of drugs/alcohol as well as someone who poses a danger to anyone at the agency. We also reserve the right to refuse or discontinue treatment to anyone who, in our professional opinion, cannot be helped by the type of outpatient treatment we provide.

JFS is not an emergency facility. For imminent suicidal or homicidal intent or for other emergency situations, you will need to seek help immediately. We recommend that you call 911 or go to the nearest hospital emergency room. You can also call the Center for Health Care Services/United Way Helpline 24 hours a day at 210-227-HELP (4357).

CONFIDENTIALITY: Your confidentiality will be respected to the limits of the law and professional ethics. Treatment records are held in the strictest confidence and information will only be released with your written permission, except as required by law and professional ethics.

Therapists are mandated by law to report abuse to appropriate regulating agencies even when abuse is suspected and not confirmed. Abuse may include: neglect, emotional, physical, sexual, or verbal. It becomes the responsibility of the regulating agency to determine whether or not they will pursue the report with an investigation or even open a case based on the report. Specific exceptions to confidentiality include:

Client's report of child abuse or neglect • Abuse of people who are elderly or disabled
Imminent risk of suicide or homicide.

In addition, professional ethics requires that the therapists seek case consultation and support when deemed necessary. All therapists at this agency are supervised, receiving individual or peer supervision

during which some cases are discussed. For clarifications regarding the exceptions to confidentiality, please speak with your therapist during your initial session.

Concerns or Complaints: We strive to provide the highest quality service. If you have a problem or a complaint, please feel free to discuss it with your therapist. If it is necessary to take the matter further, you may contact the Clinical Director or the Chief Executive Officer.

An individual who wishes to file a complaint against a Licensed Professional Counselor may call 1-800-942-5540 or write the Texas State Board of Examiners of Professional Counselors at 1100 W. 49th Street, Austin, Texas 78756. An individual who wishes to file a complaint against a Licensed Social Worker may call 1-800-232-3162 or write the Texas State Board of Social Work Examiners, P.O. Box 141369, Austin, Texas 78714-1369. An individual who wishes to file a complaint against a Licensed Marriage and Family Therapist may call 1-800-942-5540 or write the Texas State Board of Examiners of Licensed Marriage and Family Therapists at PO Box 141369, Austin, Texas 78714.

Appointments: Consistency is important to effective treatment and if you are unable to attend sessions consistently, your therapist will have to evaluate whether or not treatment can continue. **Your appointment time is reserved exclusively for you. If you must cancel an appointment, please do so at least 24 hours in advance. If you do not cancel your appointment at least 24 hours in advance or fail to show up for a scheduled appointment, you will be charged a fee.** Appointments can be made, cancelled or rescheduled by calling our office at 210-302-6920. Voicemail will take cancellation messages when the office is closed. Again, JFS MUST ENFORCE A 24 HOUR CANCELLATION POLICY, which requires that you (the Client) cancel your appointment 24 hours in advance of the scheduled appointment during office hours, 9am to 8pm Monday-Thursday or 9am to 4pm Friday. If you fail to follow this policy, you will be subject to charges for missed or late cancelled appointments.

Office, Billing and Insurance Policies: JFS utilizes a third party billing service (AIM Billing Service) for all billing and insurance needs. Payment is due at the time of service. In the event that your account is sent to collections, a 20% collection fee will be added to the balance on your account. There will be a $25.00 service charge on all returned checks.

Insurance Clients: If you have a deductible and the deductible has not been met, it is your responsibility to pay the full fee until the deductible has been met. It is your (the Client) responsibility to pay any co-pay, co-insurance and/or any other balance not paid by insurance at the time of service.

By signing below, I agree to the following:

- I consent to treatment for myself or minor dependent.
- I am signifying that I have read and understand all of this information.
- I authorize that JFS may utilize a billing service to handle my billing account.
- I understand that I am responsible for the full amount of my bill for services provided by JFS, and that payment is due at the time of service.
- I authorize direct payment to JFS from myself and/or my insurance company(s).
- I hereby permit a copy of this to be used in place of an original.
- I have read the Late Cancellation and No Show Policy and agree to its terms.
- I have received the agency's Notice of Privacy Policies.

Print Client Name	Client SSN
Client Signature	Date
Guardian, if applicable. Please print	Guardian Signature

Revised 7/2019

Jewish Family Service
12500 N.W. Military Hwy., Suite 250
San Antonio, TX 78231
210-302-6920 | Fax 210-302-6952

Mission Reach Wellness & Counseling Center
1151 Mission Road
San Antonio, TX 78210
210-533-1112 | Fax 210-533-1113

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of protected health information. We are also required by law to provide you with this notice of our legal duties and privacy practices concerning your protected health information. By law we must follow the terms of the notice of privacy practices that we have in effect at this time. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices, and you may request a copy of our current notices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we may maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your protected health information.
- Your privacy rights in your protected health information.
- Our obligations concerning the use and disclosure of your protected health Information.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Jewish Family Service privacy officer for HIPAA compliance or the administrator at 210-302-6920.

Client Copy; Please obtain for your personal records.

C. <u>WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION IN THE FOLLOWING WAYS:</u>

The following categories describe the different ways in which we may use and disclose your protected health information:

1. **Treatment.** Our organization may use your protected health information to treat you. This includes communicating with other health care professionals regarding your treatment, coordinating, and managing your health care providers with others. For example, we may use information about you to provide PHI to therapists, physicians, service coordinators and other personnel involved in mental health treatment services provided to you.

2. **Payment.** Our organization may use and disclose your protected health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your protected health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your protected health information to bill you directly for services and items.

3. **Health Care Operations.** Our organization may use and disclose your protected health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our organization may use and disclose your protected health information to contact you and remind you of visits/deliveries, such as voicemail messages, postcards, or letters.

5. **Health-Related Benefits and Services.** Our organization may use and disclose your protected health information to contact you to inform you of health-related benefits or services that may be of interest to you.

6. **Others Involved In Your Healthcare.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your care.

7. **Disclosures Required By Law.** Our organization will use and disclose your protected health information when we are required to do so by federal, state or local law.

8. **Public Health Risks.** Our organization may disclose your protected health information to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding potential risk for spreading or contracting a disease or condition

- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult Client (including domestic violence); however, we will only disclose this information if the Client agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

9. **Health Oversight Activities**. Our organization may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

10. **Lawsuits and Similar Proceedings.** Our organization may use and disclose your protected health information in response to a court or administrative order, if you are involved IN A LAWSUIT OR SIMILAR PROCEEDING. In certain circumstances, we also may disclose your protected health information in response to a discovery request, subpoena, or other lawful process.

11. **Law Enforcement.** We may release PHI when the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.

12. **Coroners, Funeral Directors, and Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or the medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out other duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

13. **Research.** Under certain circumstances, we may disclose PHI about you for medical research.

14. **Serious Threats to Health or Safety.** Our organization may use and disclose your protected health information to medical or enforcement personnel when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

15. **Military.** Our organization may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

16. **National Security.** Our organization may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your protected health information to federal officials in order to protect the President, other official or foreign heads of state, or to conduct investigations.

17. **Inmates.** Our organization may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official in order to provide health care to you.

18. **Worker's Compensation.** Our organization may release your protected health information for workers' compensation and similar programs.

D. REQUIRED USES AND DISCLOSURES

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

E. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION.

- **Authorization for Other Uses and Disclosures.** Other uses and disclosures of you protected health information will be made only with your written authorization, unless otherwise permitted or required by as described above. With some exceptions, we must obtain an authorization for uses or disclosures of psychotherapy notes. Any authorization you provide to us regarding the use and disclosure of your protected health information may be revoked at any time in writing except to the extent that we have taken action in reliance on the use and disclosure indicated in the authorization. Please note: we are required to retain records of your care.
- **Highly Confidential Information.** Special privacy protections by state and federal regulations may apply for certain highly confidential information such as information about alcohol and drug abuse.
- **Texas Law.** Certain provisions of Texas Law may be more stringent than HIPAA. If such provisions are more stringent than HIPAA, we must comply with these more stringent provisions of Texas Law.

F. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to JEWISH FAMILY SERVICE PRIVACY OFFICER or contact us at 210-302-6920 for further information specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your protected health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your protected health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your protected health information, you must make your request in writing to JEWISH FAMILY SERVICE PRIVACY OFFICER or call 210-302-6920 for further information.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the protected health information that may be used to make decisions about you, including client medical records and billing records. Some exceptions might apply. You must submit your request in writing to JEWISH FAMILY SERVICE PRIVACY OFFICER or call 210-302-6920 for further information. We may charge you related fees, unless prohibited by law. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, in certain circumstances, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your protected health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to JEWISH FAMILY SERVICE PRIVACY OFFICER or call (210) 302-6920 for further information. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the designated record set; (c) not part of the protected health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is no available to amend the information.

5. **Accounting of Disclosures**. All of our Clients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a a list of certain disclosures our organization has made of your protected health information for purposes other than for treatment, payment, healthcare operations and certain other activities. In order to obtain an accounting of disclosures, you must submit your request in writing to JEWISH FAMILY SERVICE PRIVACY OFFICER or call (210) 302-6920 for further information. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices even if you have a notice electronically. You may ask us to give you a copy of this notice any time. To obtain a paper copy of this notice, contact JEWISH FAMILY SERVICE PRIVACY OFFICER or Administrator, or call 210-302-6920 for further information.

7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our organization and with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact the JEWISH FAMILY SERVICE PRIVACY OFFICER or Administrator, or call 210-302-6920 for further information. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

THIS NOTICE WAS PUBLISHED AND BECAME EFFECTIVE ON APRIL 14, 2015
REVISED ON APRIL 24, 2015

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize **Jewish Family Service** to use and disclose a copy of the specific health and medical information described below regarding:

CLIENT NAME: ____

DOB: ________________________________ SSN: ______________________________________

ADDRESS: ____

The following information to be used/disclosed: ____________________________________

____

Purpose of Release: ❑ At the Request of the Individual ❑ Other: ___________________________

Release Information To:	**Release Information From:**
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

If we are requesting this Authorization from you for our own use and disclosure, or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of treatment to you on whether you sign this authorization unless it is research related treatment and the use and disclosure is for PHI for such research or the health services are solely for the purpose of creating PHI for disclosure to a third party and the authorization is for disclosure to such party.
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization in writing at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire on ______________________________.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Client Signature____ Date: _______________

Signature of Legal Representative____ Date: _____________

Description of Legal Representative's Authority ____