Jamie M. Stumbo, MS, LMFT

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, _____, _____
(Full Name of Client) (Social Security Number) (Date of Birth)
authorize and give this consent voluntarily. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing information has been explained to me. I also understand that provision of services is not contingent on my decision concerning this release of information.

☒ From: Jamie M. Stumbo, MS, LMFT
543 Terry Lane, Suite #2
Crescent Springs, KY 4101

☒ To: (Full name and address of individual/agency)
ComMa – Comprehensive Medical Administrators
8300 Princeton Glendale Rd #102
West Chester, OH 45069
513-860-0847, Fax: 513-860-1459

☒ To: Jamie M. Stumbo, MS, LMFT
543 Terry Lane, Suite #2
Crescent Springs, KY 4101

☒ To: (Full name and address of individual/agency)
Same as above

Please document the information you would like shared with this individual/agency:
Information needed to use for billing purposes: Client data sheet, insurance information, DX, and dates of service

Purpose for release:

☐ Report client progress ☐ Verify attendance ☐ To obtain collateral information in treatment of this client
☒ Other: (Specify): For billing insurance provider for services

This authorization expires ONE YEAR from the date of your signature below or 180 days after end of treatment**.**

PROHIBITION ON REDISCLOSURE

This information has been disclosed to your from records whose confidentiality is protected by federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Parent/Legal Guardian Date

Signature of Clinician _____ _____

REVOCATION OF RELEASE

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

_____
Signature of Client/Parent/Guardian Date Revoked