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### **Authorization for Disclosure of Consumer Medical/Health Information**

I, (client) \_\_\_\_\_ authorize and request JARODGIGER, LLC disclose/release the below specified information of (client) \_\_\_\_\_, (date of birth): \_\_\_\_\_, (social security number) \_\_\_\_\_, who received services from \_\_\_\_\_ (date) to \_\_\_\_\_ (date) to **(Identify those whom you wish to have information released)** \_\_\_\_\_

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The purposes of this disclosure are continuity of services/care and the gathering of collateral information. The specific information to be disclosed is all clinically relevant information.

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical records includes mental/behavioral information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency virus, other communicable diseases, and/or alcohol/drug abuse.
  2. Alcohol and drug abuse information records are specifically protected by federal regulations and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information: **(client)** \_\_\_\_\_.
  3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named business during the specified time frame.
  4. This authorization becomes effective on \_\_\_\_\_ (date). This authorization automatically expires on the following date, event or special condition \_\_\_\_\_.
  5. If I fail to specify an expiration date, this authorization will **expire in one year**.
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