The Jilan Center

Third-Party Authorization Form

Client Information

Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Address: _____

Authorized Third Party

Name: _____

Relationship to Client: _____

Phone Number: _____

Email: _____

Scope of Authorization

[ ] Appointment Scheduling

[ ] Medical or Service Records

[ ] Billing and Payment Information

[ ] Treatment Plan and Progress Notes

[ ] Other

Purpose of Disclosure

[ ] Coordination of Care

[ ] Insurance and Billing

[ ] Legal Representation

[ ] Other

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Authorization Duration

This authorization is valid until: _____ OR [ ] Until Revoked in Writing

Client Consent & Signature

I understand that I have the right to revoke this authorization at any time by submitting a written request to The Jilan Center. Revocation will not affect any disclosures made prior to the receipt of the request. I understand that The Jilan Center is not responsible for any actions taken by the third party after the information is disclosed.

Client Signature: _____

Date: _____

For Internal Use Only

Received By: _____

Date Processed: _____

Notes: _____

The Jilan Center respects your privacy and confidentiality. For questions, contact us at (213) 264-9951 or email info@thejilancenter.org.