Consent to Release Information

I, Name:______________________________(client name or Guardian on behalf of minor)
D.OB.____________Address:____he
reby authorize Hope and Wellness Center, P.C. to disclose to and receive information from:
______ Employer/Human Resources/Supervisor ________________________________
______ Referral Resource____
______ Treatment Provider____
______ Third Party Payer____
______ Other ____

INFORMATION and PURPOSE for RELEASE

Authorization is hereby given to exchange information in written, verbal, or electronic form regarding the above named individuals between the above listed agencies and individual(s) to be used for the purpose(s) of:

Assessment Coordination of Services Continuity of Care Insurance Legal Other

The specific information to be exchanged is as follows:

______ Aftercare/Discharge Plan
______ Current Medications
______ Discharge Summary
______ Drugs/Alcohol Information/Evaluation
______ Financial Resource and Eligibility
______ Individual Education Plan
______ Social History
______ Medical History
______ Progress Reports/
_______Summary of Treatment
______ Psychiatric History & Diagnosis
______ Psychological Testing
Information
______ Treatment Service Plan
______ Other ____

If requested records include drug and alcohol information, I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
I understand this Release of Information may be revoked at any time, except to the extent that action has already been taken and reliance on this Release of Information. I understand if I wish to revoke this Release of Information, I must do so in writing and present my written revocation to Hope & Wellness Center, P.C. Unless otherwise revoked, this Release of Information will expire on the following date, event, or condition: ________. (90 days for one time request/180 days for ongoing services.) If I fail to specify an expiration date, event, or condition, this Release of Information will expire one hundred eighty (180) days from the date below. I understand this Release of Information is voluntary. I can refuse to sign this Release of Information. I need not sign this Release of Information in order to receive treatment. I understand that I may inspect or copy this information to be used or disclosed, as provided for in, and subject to the limitations of, 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may no longer be protected by federal and state confidentiality laws.

By signing this form, I consent to the service provider identified above disclosing my protected health information:

_____________________________________ __________
Client Signature Date

____________________________________ ___________
Guardian Signature (If applicable) Date

____________________________________ ___________
Counselor Signature Date