Wellspring Center for Counseling

Authorization for Release of Confidential Information

I understand that the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I understand that I have the right to inspect information that is released and that no information may be re-released that is provided by a third party. I also understand that I may ***revoke*** *this authorization/consent by notifying Wellspring Center for Counseling, LLC, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Wellspring Center for Counseling, LLC in reliance on it before I revoked it. I understand that I may* ***refuse*** *to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. A photocopy of this authorization will be treated in the same manner as the original.*

Client Name: _____ DOB: _____

Address: _____

I authorize Wellspring Center for Counseling to _____ receive information from:

and / or to _____ release information to:

Agency/Individual: _____

Address: _____

Phone: _____ FAX: _____

This release is required for the purpose of: (*Check boxes that apply*)

☐ Coordination of services ☐ Determination of eligibility for services ☐ Court/Legal Purposes

☐ Continued / Follow-up care ☐ Insurance/Billing/Payment ☐ At the Request of the Individual

☐ Mental Health Records Review ☐ Other _____

Information to be disclosed: (*All 4 of these must be selected for any info to be released)*

☐ Name ☐ Address ☐ Phone Number ☐ Date of Birth

☐ Any and all mental health records and ongoing communication

OR the following only:

☐ Dates of Services and Discharge ☐ Family / Social History ☐ Treatment Plan /Progress Notes

☐ Insurance/Billing/Payment Information ☐ Diagnosis Information ☐ Other:_____

ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, AND/OR AIDS/AIDS RELATED ILLNESES WILL BE RELEASED UNLESS OTHERWISE INDICATED IN WRITING HERE: _____

I understand this authorization/consent will expire on: _____

_____ _____

Signature of Client Date

_____ _____

Signature of Parent, Legal Guardian or Personal Representative *(if applicable)* Date

_____ _____

Witness Date