

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)

- | | | |
|---|--|---|
| <input type="checkbox"/> Coordination of services | <input type="checkbox"/> Determination of eligibility for services | <input type="checkbox"/> Court/Legal Purposes |
| <input type="checkbox"/> Continued / Follow-up care | <input type="checkbox"/> Insurance/Billing/Payment | <input type="checkbox"/> At the Request of the Individual |
| <input type="checkbox"/> Mental Health Records Review | <input type="checkbox"/> 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dates of Services and Discharge | <input type="checkbox"/> Family / Social History | <input type="checkbox"/> Treatment Plan /Progress Notes |
| <input type="checkbox"/> Insurance/Billing/Payment Information | <input type="checkbox"/> Diagnosis Information | <input type="checkbox"/> Other: _____ |

ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, AND/OR AIDS/AIDS RELATED ILLNESSES 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

