

Sharon G. Richardson, LCSW-C
The Health and Wellness Source, LLC
4451 Parliament Place, Suite A, Lanham, MD 20706
www.thehealthandwellnesssource.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of the Client: _____ **Date** _____
Date of Birth: _____ **SSN:** _____

Name of Third Party to Receive/Send Information:

Name: _____ **Date:** _____
Organization: _____
Address: _____
City/State/Zip: _____
Phone: _____ **Fax:** _____

Description of information to: Disclose Receive Exchange (Disclose and Receive)
Formats of information: Written Spoken Electronic (e-mail)

Assessments/Diagnostics:

Diagnosis
 Psychosocial History
 Intake Summary

Discharge:

Discharge Summary
 Discharge Plans
 Prognosis/Recommendations

Treatment:

Treatment Plan
 Progress Notes
 Status and Progress Reports

Other:

Other: _____

At the request of individual or personal representative: Yes No

Limited to a single disclosure: Yes No

I understand that my records are protected by Federal and/or State confidentiality laws and regulations and that they cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke this authorization at any time by written notification. Revocation will not apply to records already furnished in reliance upon this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. I acknowledge that the information to be released was explained to me and that this consent is given of my own free will.

Signature of Client or Person Authorizing Disclosure:

Signature: _____ **Date:** _____

Person authorizing disclosure is: Client Personal Representative Parent of Minor
 Guardian Power of Attorney In Loco Parentis

If other than client, name: _____ **Relationship:** _____

Name and Signature of Staff Completing/Explaining Form:

Name: _____ **Date:** _____

Signature: _____

This information may have been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules prohibit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient except as authorized by a court order granted after application showing good cause.

A COPY OF THIS FORM IS AS VALID AS THE ORIGINAL