Release of Information Consent

Client's Name: ____

Address: __________________________________City:____________________State:_____Zip Code: _______

Phone: __________________________ DOB: _______/_______/________

I, ____, authorize **Integrative Health & Wellness Inc**. to

send/receive the following **to/from** Name(Agency/Person): __________________________________
(circle above) (circle above)

Address: __________________________________City:__________________State:_____Zip Code: ________

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

______ Academic testing results
______ Behavior programs
______ Progress reports
______ Intelligence testing results
______ Medical reports
______ Personality profiles
______ Psychological reports
______ Psychological testing results
______ Service plans
______ Summary reports
______ Vocational testing results
______ Entire record, except progress notes
______ Psychotherapy notes
______ Others, specify ______________________________

The above information will be used for the following purposes:

______ Planning appropriate treatment
______ Continuing appropriate treatment
______ Determining eligibility for benefits
______ Case review ______ Updating files
______ Coordinate Care
______ Other (specify) ____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. After 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.
This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above. This consent may be terminated at any time by a written notice from the client or legal guardian.

Your relationship to client: ____Self ____Parent/legal guardian ____Legal representative

____Other (describe) ____________________________________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ______________________________ Date ____/ _____/ ____

Signature: ____________________________________ Date ____/ _____/ ____
Parent/guardians/personal representative (if applicable)

Signature: ____________________________________ Date ____/ _____/ ____
Witness (if client is unable to sign)