COMMUNITY WELLNESS FOUNDATION LLC

AUTHORIZATION FORM FOR RELEASE OF INFORMATION

I, _______________________________ whose Date of Birth is ____/____/______, authorize Community Wellness Foundation llc to disclose to and/or obtain from:

____ the following information:

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____ Assessment.
_____ Diagnosis.
_____ Psychosocial Evaluation.
_____ Psychological Evaluation.
_____ Psychiatric Evaluation.
_____ Treatment Plan or Summary.
_____ Current Treatment Update.
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______Other_______________________
______Other _____________________

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify: ____

____

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Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to ____ at ___________________________________ I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date:________________ or as otherwise indicated: ____

Conditions

I further understand that authorize Community Wellness Foundation llc will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

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Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

____

Signature of Client   Date

____

Signature of Parent, Guardian or Personal Representative   Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____

Signature of CWF Staff Witness   Date