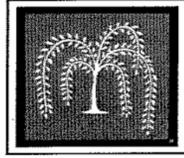
AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION



CLIENTS NAME:____Date of Birth:_____________

Requesting Entity:__Willow Medical and Wellness______	Releasing Entity:______________________________
____________________920 E 72nd Ave_____________ Street Address	____ Street Address
____________Anchorage, AK 99518_________________ City / State / Zip	____ City / State / Zip
_____907-222-0754_____/_______907-222-0753_____ Fax Phone	_____________________/_____________________ Fax Phone

__________(initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

________Psychological Evaluations/Reports

________Psychiatric Evaluations/Reports

________Physical / Medical Records / Med. List

________Lab Results

________Radiology Reports (CT/MRI)

________Emergency Reports

________Psychotherapy Notes

_________Social History

_________Vocational/ Work Information

_________Discharge Summary (ies)

_________Verbal Information

_________ Any documents which may include information regarding **HIV status**.

_________Any documents which may include information regarding **chemical dependency.**

_________Other ____________________________

I hereby authorize the above information to be released to the party I have indication for the purpose of:
______continuity of care _______ other:____
I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.

*I understand that authorizing the disclosure of the above information is **voluntary** and I need not sign this form to ensure treatment.*

____ ______________________________
Signature of Client or Client's Designee *Designee's Relationship to Client*

____ ________________ *TO* __________________
Witness *Date Authorized* *Date Authorization ends*