RELEASE OF INFORMATION

WILLOW MEDICAL
& wellness

CLIENTS NAME:_____Date of Birth:_____

Today's Date: _____

Requesting Entity:	Releasing Entity:_____
Willow Medical & Wellness 920 East 72nd Avenue Anchorage AK 99518 Tel: 907.222.0753 Fax: 907.222.0754	_____ Street Address _____ City / State / Zip _____/_____ 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*