RELEASE OF INFORMATION

WILLOW MEDICAL
& wellness

CLIENTS NAME:______________________________	Date of Birth:__________
	Today's Date: __________

Requesting Entity:______________________	Releasing Entity:______________________
______________________ Street Address	______________________ Street Address
______________________ City/State/Zip	______________________ City / State / Zip
__________/__________ 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*