Authorization of Release of Records or Information

Client's Name: _____

DOB:_____

I, _____, hereby give permission to **Great Lakes Counseling and Wellness Center, LLC**, or any clinician performing services on behalf of **Great Lakes Counseling and Wellness Center, LLC**, in connection with my treatment, to:

_____ Disclose information to: AND/OR **_____ Obtain information from:**

_____ _____
(Name of agency, physician, attorney, school counselor, therapist, etc.) *(Name of agency, physician, attorney, school counselor, therapist, etc.)*

_____ _____
(Address, city, state, and zip code) *(Address, city, state, and zip code)*

Phone: ( )_____ Phone: ( )_____

_____ **MY ENTIRE RECORD; OR**

_____ **ONLY THE FOLLOWING INFORMATION: (Patient must initial each item to be released/obtained)**

_____ Attendance Information
_____ Treatment Recommendations
_____ Expected Length of Treatment
_____ Substance Abuse Evaluation Results
_____ Other (specify): _____

_____ General Progress Report of Treatment
_____ Level of Risk to Self or Others Information
_____ Treatment Plan
_____ Diagnosis / Assessment

The purpose of this disclosure is:
_____ to permit continuity of care.
_____ to permit case management (including reimbursement determinations) and processing of benefit claims.
_____ Other (specify): _____

The timeframe for which this release of information is applicable is for **one (1) year** from the date signed.

The undersigned hereby authorizes and gives this consent voluntarily. I understand that I have a right to inspect the information being released as permitted under the Privacy Rules. I also understand that the provision of the services is not contingent on my decision concerning this release of information, unless I am receiving treatment/services solely for the purpose of creating information for disclosure to a third party or if I am receiving research related treatment.

I understand that GLCWC cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.

I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider.

_____ _____
Signature of Client / Custodial Parent / Legal Guardian Date