A Window to Wellness, LLC

AUTHORIZATION OF HEALTH CARE INFORMATION

I, _____, Date of Birth: _____ Maiden/Previous name: _____;

authorize A Window to Wellness, LLC to do the following with my mental health care information:

____ REQUEST FROM ____ RELEASE TO ____COMMUNICATE WITH

Name/Organization: _____ **Relationship to Client:** _____

Address: _____

City & State: _____ **Zip Code:** _____ **Phone #:** _____

Release/Discuss the following information:

____ Billing Matters, **ONLY**

____ *Health care information relating to the following treatment or condition:* _____

_____

____ *Health care information for the date(s) below:* _____

____ ***All*** *health care information*

The purpose of the disclosure: ___ Continuity of Care ____ Billing Resolution

____ Inter-office collaboration ___ Transfer of Records/Care____ Progress/Compliance of Care

____Other: _____

This authorization will expire when treatment is discontinued, or, as of this date: _____

____ I understand that I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are two ways to cancel this authorization:

1) Write, sign and date a letter to the clinician to cancel the authorization; or
2) Sign, date and write "CANCEL" on this original form

____ I understand that once the provider gives out the information, the provider has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it. I acknowledge that I am signing this consent in the absence of coercion, duress or deceit.

If the purpose of this release is pertaining to records release/request, review and initial the following acknowledgements, as well. *If not, you may disregard them by indicating "N/A".

____ I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for the following: HIV/AIDS status, Sexually transmitted diseases, Psychiatric/mental health disorders, and/or Drug/Alcohol Usage; which may be referenced in my records.

____ I understand that my mental health, substance use or other addiction disorder issue records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The consent shall be valid only for the period reasonably necessary to accomplish the purpose for which it was given. I understand that in generality, a treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

____ I understand that there may be fees associated with records requests, from A Window to Wellness or the other Entity, which are my financial responsibility.

_____ _____ _____

Client/Legally Authorized Individual Signature | Date | Relationship to Client

Witness Signature for Consent to Release of Information _____

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