INTOWN COUNSELING & WELLNESS

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AUTHORIZATION AND CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

When completed and signed, this form authorizes me to release protected information from your clinical records to the person you designate.

Name:	
DOB:	

I authorize my therapist/ psychologist to obtain/ release the following information:

- ☐ Discharge Summary
- ☐ Psychological Evaluation
- ☐ Psychosocial/ Intl. Clinical Assessment
- ☐ Medication Records
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Continuing of Care Plan
- ☐ History & Physical Exam
- ☐ Other (Specify): _____

This information should only be obtained from / released to the following:

Provider Name:	
Street Address:	
City, State, Zip Code	
Phone #:	
Fax #:	

I am requesting my therapist/ psychologist to obtain/ release this information for the following reason, and subject to the following limitations:

This consent will expire one (1) year from the date hereof unless otherwise stipulated. I understand that information received or medical records prepared after this release form is completed, regarding my condition and the services I have received in the course of my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. I understand that the records released may contain alcohol and drug treatment information, AIDS/HIV information or psychiatric/psychological/ psychosexual information. I understand this communication will reveal my presence as a patient in a treatment facility.

After giving due consideration to the above statements, I authorize the above person/ organization/ and or members of their staff, to furnish the above information, including photo static or faxed copies of my medical records to the above organization or to its agents. I further agree to release Intown Counseling & Wellness, LLC and its employees and agents from all liability that may arise from the release of information herein requested. I understand that Intown Counseling & Wellness, LLC reserves the right to notify the above-name person, corporation or agency of my revocation in the event that I revoke this consent to release information.

_____ _____

Signature of Patient or Legal Guardian **Date**