Grand Junction
Wellness Center

Authorization for the Release of Confidential Health Information

I ____________________________, authorize ___________________(therapist name) and _______________ (check if applicable) to disclose to and/or obtain from ________________________, the following information (mark all that apply).

	Assessment		Nursing/Medical Information
	Diagnosis		Educational Information
	Psychosocial Evaluation		Discharge/Transfer Summary
	Psychological Evaluation		Continuing Care Plan
	Psychiatric Evaluation		Progress in Treatment
	Treatment Plan or Summary		Demographic Information
	Current Treatment Update		Psychotherapy Notes
	Medication Management Information		Other____________________________
	Presence/Participation in Treatment		Other ____________________________
	Submit session information/CPT code(s) and initials for **third party payment and reimbursement for services** provided.		

Purpose

The information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is otherwise, specify below:

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Revocation:

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to __________________ (therapist name) at __________________ (therapist email), and _______________________. I further understand that revocation of this authorization is not effective to the extent that action has already in reliance on this authorization.

Expiration:

Unless revoked, this authorization remains in effect in perpetuity. If specific date is indicated for expiration, note here: _____________________________

Conditions:

I understand that ________________ (Therapist Name) will not condition my treatment on whether or not I give authorization for the requested disclosure. Unless, the disclosure is necessary for payment of professional services/clinical fees for which an arrangement has been made.

Form of Disclosure:

Unless you have specifically requested otherwise in writing that the disclosure be made in a certain manner or format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law, including, but not limited to, verbal, in paper format, or electronic.

Redisclosure:

I understand that there is the possibility that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more restrictive than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

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Signature of Client **Date**

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Signature of Parent, Guardian or Personal Representative **Date**

If you are signing on behalf of an individual, describe your relationship and/or authority to act on behalf of the individual (MDPOA, Healthcare surrogate, etc.)

Signature of Witness/Staff ________________________________ ______________

Date