YOUR LIVING WELL PLLC / Release of Information Consent Form

1. PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____

2. I AUTHORIZE

Your Living Well PLLC (YLW PLLC)
C/o _____(Provider Name)
1721 W. Plano Pkwy #216 Plano TX, 75075
214-543-5977

To: ☐ Release information to ☐ Obtain information from

☐ Exchange information with

3. ORGANIZATION/INDIVIDUAL INFORMATION

Organization Name: _____

Person Name (Required): _____

Address: ___

Phone: ___ _ Fax: _____

4. INFORMATION TO BE RELEASED

☐ Specific dates/years of treatment: _____

☐ All health information (excludes information from a chemical dependency program & psychotherapy notes)

OR indicate the specific categories to be released below:

☐ Diagnosis ☐ Psychological Evaluations ☐ Discharge Summary

☐ Treatment Plans ☐ Social History ☐ Provider/Hospital

☐ Other: _____

5. Method of information disclosure:

☐ Email ☐ Mail ☐ Fax ☐ Telephone

6. **PURPOSE FOR DISCLOSURE:**

   ☐ Continuity of care ☐ Other

7. **ROI is valid for 1 calendar year beginning on _____ unless cancelled by client.**

8. **I UNDERSTAND THAT:**

   - My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in YLW's Initial Contract and Hipaa acknowledgement agreement .
   - I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Contacting Kimberly Kline at kklines5@protonmail.com and requesting the revocation is the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
   - For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))
   - Communications resulting from this authorization will reveal that I receive services at YLW PLLC.
   - Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires YLW PLLC to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
   - This authorization may be used by YLW PLLC owned or managed programs upon transfer of my care to them.

9. **SIGNATURE**

   Patient's Signature: _____ Date: _____

   OR Authorized Representative's Signature: _____ Date: _____

   Representative's Name (printed): _____

Representative's Relationship to Patient: _____