



YOUR LIVING WELL PLLC / Release of Information Consent Form

1. PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____

2. I AUTHORIZE

Kimberly Kline LPCS
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): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

4. INFORMATION TO BE RELEASED

Specific dates/years of treatment: _____

All health information (excludes information received from any outside source)

OR indicate the specific categories to be released below:

Diagnosis Discharge Summary

Treatment Plans Social History Provider Recommendation

Other: _____

5. Method of information disclosure:

Email Mail Fax Telephone Other _____

6.

7. PURPOSE FOR DISCLOSURE:

Continuity of care Other _____

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

9. 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.

10. SIGNATURE

Patient's Signature: _____ Date: _____

OR Authorized Representative's Signature: _____ Date: _____

Representative's Name (printed): _____

Representative's Relationship to Patient: _____