Living Well International Center, PC

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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client Name: _____DOB: _____Record #: _____

I, _____, hereby authorize Living Well International Center to share specified protected health information in my/my child's medical record with_____ _____ _____ located at _____. I further authorize _____to release specified protected health information in my/my child's record to Living Well International Center. The purpose of the disclosure: Assist with treatment ☐ Referral ☐ At Request of Client ☐ ☐ Other_____

This information shall include only the following:

Initial	Information	Date Released	Initial	Information	Date Released
	Treatment Progress Summary			Diagnoses/Psychiatric Information	
	Service Plan Documentation			Discharge Summary	
	Progress Note Documentation			Verbal Communication	
	Alcohol/Drug Treatment Information*			Psychological Information	
	Medical History and Physical			Emotional Support Animal Letter for Travel	
	Emotional Support Animal Letter for Housing			Other (List):	

My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred.

I understand that the above recipient party, without my further consent, may not release this information, and that Living Well International Center, PC is required by HIPAA privacy law to protect my health information. However, once she discloses information, I understand she has no control over my privacy with regards to the recipient of the information.

This consent will automatically expire on: _____ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization.

_____ _____
Client Signature Date

_____ _____
Guardian (Relationship to Client) Date

_____ _____
Therapist Date

*Client must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2