RELEASE OF INFORMATION

Emotional Wellness Center of Valdosta

Patient Name : _____ **Date of Birth :** _____

I authorize EWC Provider to ____ release ____ receive the following information *(check all that apply):*

_____ Results of psychological and/or educational testing
_____ Counseling/psychological treatment notes
_____ Treatment Summary Letter:
- (includes dates of service, diagnosis(es), brief summary of treatment, and recommendations)

_____ Medical information
_____ Educational
_____ Legal
_____ Appointment Scheduling/Canceling/Confirmation
_____ Other; Specify: _____

I authorize EWC Provider to exchange the specified information with the following entity:

Name/Agency : _____

Address : _____

Phone/ Fax : _____

Purpose of Disclosure *(check all that apply)*:

_____Continuing Care
_____At the Request of the Patient
_____Other; Specify : _____
_____

Method of Personal Disclosure :

Private/Confidential Email Address :
_____
Private Mailing Address :
_____
Confidential Fax Number : _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to our office address. However, your revocation will not be effective to the extent that EWCV Provider has acted in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If no written authorization is received, this authorization shall remain in effect until a year from the date this form was signed. I understand that EWCV Provider generally may not condition services upon my signing an authorization unless the services provided to me are for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclose by the recipient of your information and is no longer protected by the HIPAA Privacy Rule. I understand that the records being provided are of a sensitive nature, as being mental health records, and that my personal evaluation of these notes may not include professional and ethical training to fully review and understand its contents. It is the opinion of EWCV that mental health records are best interpreted through a clinical lens, so patient review of these records is recommended to be with the assistance of another trained, mental health or medical professional. I understand that services may be terminated if the treating clinician is placed in a dual role at any time, in accordance with our Code of Ethics and governing ethical principles and standards. I understand that EWCV **WILL NOT** produce records of sessions that include other parties without explicit and written consent from those participants. I understand that "psychotherapy notes" **WILL NOT** be provided, which include notes recorded (in any medium) documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient **Date**

If the authorization is signed by a personal representative of the patient, a description of and documentation supporting such representative's authority to act for the patient must be provided.

Kelly D. Jones, LCSW | Anna Osborne, LMFT | Cassie Avellaneda, LPC, LMHC
1102 Williams Street Valdosta, GA 31601
Phone: (229) 588-2266 Fax: (229) 506-6877 Email: Frontdesk@ewcvaldosta.com