AUTHORIZATION FOR OBTAINING AND RELEASING CONFIDENTIAL INFORMATION

I, ________________________________, whose date of birth is ___/___/___, authorize Wildflower Center for Emotional Health LLC to disclose to and/or obtain from:

______________________________ at ____ the following information:
[Name of Person or Organization] [Address and Phone Number]

Description of Information to be Disclosed/Obtained

__ Assessment
__ Diagnosis
__ Psychosocial Evaluation
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Plan or Summary
__ Current Treatment Update
__ Medication Management Information
__ Presence/Participation in Treatment
__ Nursing/Medical Information
__ Educational Information
__ Discharge/Transfer Summary
__ Continuing Care Plan
__ Progress in Treatment
__ Demographic Information
__ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
__ Other ____________________________
__ Other ____________________________

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than as specified above, please specify:
____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Aga Grabowski or Christina Johnson at Wildflower Center for Emotional Health. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _________ or as otherwise indicated: _________

Conditions: I further understand that Wildflower Center of Emotional Health LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ____

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

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed 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 strict than HIPAA and provides additional privacy protections.

If requested, I will be given a copy of this authorization for my records.

☐ I decline to sign this authorization

______________________	______________________	______________
Client Signature	Client's Printed Name	Date
______________________	______________________	______________
Wildflower Staff Signature	Wildflower Staff Printed Name	Date