



Wellness Counseling & Therapy Services
 Don't Let Your Mind Be An Obstacle

www.wellnesscounselingclinic.com
 Phone: 630-214-4000
 Email: info@wellnesscounselingclinic.com

Authorization of Release of Information

Name _____ Date of Birth _____

Email Address _____ Phone: _____

I hereby authorize Wellness Counseling & Therapy Services and its affiliated mental health therapists and health care providers to use or disclose my protected health information (PHI) to (please provide person name or clinic) _____

I authorize the release of my PHI covering the period of health care (check one):

all past, present and future periods or From (date) _____ to (date) _____

I hereby authorize the release of my PHI as follows (check one):

my complete health record (including records relating to mental health care and psychotherapy notes, communicable diseases, HIV/AIDS, and treatment of alcohol/drug abuse)

OR

my complete health record with the *exception* of the following information:

mental health records

communicable diseases (including HIV/AIDS)

alcohol/drug abuse treatment

other (please specify): _____

By signing below, I understand that:

My treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I choose to sign this authorization form.

I may revoke this authorization at any time in writing to the Privacy Officer at Wellness Counseling & Therapy Services; however, the revocation will not affect any uses or disclosures that were made prior to Wellness Counseling & Therapy Services receiving the revocation.

The information disclosed pursuant to this authorization form may be subject to re-disclosure by the recipient of the information and thus, will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

This authorization form is valid from the date it is signed and will not expire. A written authorization is required to revoke the authorization.

I have read the above and understand the contents of this authorization form and as such, I authorize the use or disclosure of my PHI.

Signature of Client (or authorized person) _____ Date: _____

If authorized signer, relationship to patient: _____ Date: _____