ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I_____for_____ authorize ATPWC to:

□ physically/verbally RELEASE □ physically/verbally RECEIVE

(as indicated below) my/my child's protected health information (PHI) to/from:

Company Name:	
Contact Person:	
Company Address:	
Company Phone No:	
Company Fax No:	

Identifying Information on Client(s) that PHI will be released on:
DOB: _____
Full Name: _____

For the purpose of review/examination, I authorize you to provide the following information:
- ☐ COMPLETE COPY OF MEDICAL RECORD
- ☐ PSYCHOLOGICAL TESTING/ASSESSMENT
- ☐ LETTER SUMMARIZING DX(S), DOS, AND TREATMENT PLAN
- ☐ DISCLOSURE LOG
- ☐ SPECIFIC INFORMATION:_____

I give specific permission to release any information related to:
- ☐ SUBSTANCE ABUSE
- ☐ PSYCHIATRIC/MENTAL HEALTH INFORMATION
- ☐ HIV/AIDS INFORMATION

This authorization does not expire. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

_____ _____
Client's or Legal Guardian's Signature Date

_____ _____
Client's or Legal Guardian's Printed Name Witness