ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ authorize the use or disclosure of my individually identifiable health information
PRINT PATIENT NAME
as described below. I understand this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to All Things Possible Wellness Center (ATPWC). If I choose to revoke authorization, I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Persons/Organization authorized to provide information is: ATPWC, located at _____.

Information to be provided ((including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services):

☐ Psychological Testing/Assessment

☐ Summary Letter of Diagnosis, Dates of Service, and Treatment Plan

☐ Disclosure Log

☐ Specific Information Including Dates of Information Sought to Be Disclosed: _____

_____

Person/Organization authorized to receive information is: _____(Name of Person/Organization).

located at _____, _____ _____
Address Phone Number Fax Number

Purpose For The Use/Disclosure:

☐ _____(Specify Purpose), or

☐ At the Request of the Patient

This Authorization is valid for one year from date signed unless another date is provided here: _____

By signing below, I understand and acknowledge the following:

- That I have read and understand the Authorization; and
- If I have any questions about disclosure of my protected health information, I may contact Steven Latawiec, MA, LPC Clinical Records Director at ATPWC.

ATPWC will not condition treatment on whether this Authorization is signed on behalf of the Patient

Signature of Patient, Legal Representative, or Parent of Minor: _____ _____
Signature Date

If you are signing as a Parent, Guardian, or Legal Representative of the Patient complete the following:

Relationship to Patient: _____Print Name: _____

Witness: _____ Date: _____