



**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:

\_\_\_\_\_ the following information:  
[Insert Name of Person or Title of Person or Organization]

**Description of Information to be Disclosed/Obtained**

- |                                                              |                                                                |
|--------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Assessment                          | <input type="checkbox"/> Educational Information               |
| <input type="checkbox"/> Diagnosis                           | <input type="checkbox"/> Discharge/Transfer Summary            |
| <input type="checkbox"/> Psychosocial Evaluation             | <input type="checkbox"/> Continuing Care Plan                  |
| <input type="checkbox"/> Psychological Evaluation            | <input type="checkbox"/> Progress in Treatment                 |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Demographic Information               |
| <input type="checkbox"/> Treatment Plan or Summary           | <input type="checkbox"/> Psychotherapy Notes*                  |
| <input type="checkbox"/> Current Treatment Update            | <small>(*Cannot be combined with any other disclosure)</small> |
| <input type="checkbox"/> Medication Management Information   | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> Nursing/Medical Information         |                                                                |

**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