Willow Tree Wellness, LLC
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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION.

I, _____, whose Date of Birth is _____, authorize Willow Tree Wellness, LLC to disclose to and/or obtain from:

[Insert Name of Person or Title of Person or Organization and contact information]

the following information:

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

☐ Assessment	☐ Nursing/Medical Information
☐ Diagnosis	☐ Educational Information
☐ Psychosocial Evaluation	☐ Discharge/Transfer Summary
☐ Psychological Evaluation	☐ Continuing Care Plan
☐ Psychiatric Evaluation	☐ Progress in Treatment
☐ Treatment Plan or Summary	☐ Demographic Information
☐ Current Treatment Update	☐ Other_____
☐ Medication Management Information	☐ Other_____
☐ Presence/Participation in Treatment	☐ Other_____

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

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 your therapist or Willow Tree Wellness, LLC. I understand that I will be asked to sign a statement confirming my wish to revoke this release and disclosure. 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 Willow Tree Wellness, 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: _____

_____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

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 stricter than HIPAA and provides additional privacy protections.

You can request a copy of this authorization at anytime.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure. This Authorization is hereby revoked starting on ___/____/_____.

_____

Signature of Patient/Client, Parent, Guardian or Personal Representative Date