www.behavioralwellnessgroup.com
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**REQUESTANDAUTHORIZATION TO RELEASE RECORDSAND INFORMATION**

I, _____, born on _____, authorize _____

Patient Name (print)
Clinician Name

☐ **To Release/Disclose To:** ☐ **To Obtain Information From:**

Name _____Relationship to Patient_____

Address _____

_____

Phone Fax

This information is for treatment planning and ongoing care. If for other reasons, please describe:

_____

**This authorization includes release of records relating to:**

☐ Mental Health
☐ Chemical Dependency Abuse Treatment
☐ HIV/AIDS
☐ Diagnoses and/or treatment relating to other communicable diseases

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I have been informed that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire automatically 90 days after the last billed session.

_____ _____ _____

Signature of Patient or Parent/Guardian Date Relationship to Patient

_____ _____ Identification Verified ☐

Signature of Witness Date **(Staff Use Only)**

**___ Revoke Previous Authorization**



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