 **COMMUNITY WELLNESS FOUNDATION, LLC**

 **(CWC)**

 **AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

I, the Undersigned, authorize: Community Wellness Foundation, LLC (CWC) and staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Once completed and signed, this authorization will remain in effect until**: \_\_\_\_\_\_\_\_\_\_\_\_\_(*one year from date signed)*

**The Mental Health Information Authorized for Release includes: (Check all that apply)**

□ Copies of Records □ Discharge Summaries □ Consultation

□ School Visitation □ Immunization Records □ Scheduling

□ Psychiatric Records □ Other Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person/Organization authorized to receive your information**:□ Case Worker □ Lawyer □ Parole/Probation Officer □ Psychiatrist □ Therapist □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Release: Coordination of Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results and or AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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**Client/Parent/Guardian Signature Date**

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**Print Name Date**