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Release of Mental Health Information

Journey Into Wellness Counseling Services LLC
Psychotherapy & Professional Education Private Practice

I,_____[Nameof Client], whose Date of Birth is_____, authorize Journey Into Wellness Counseling Services LLC & Julie Wells LCSW, CP to disclose to and/or obtain from:

_____the following information:
[Name of Person or Organization]

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

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Other
_____ Other_____

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 marketing, sale of information, research or 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 Journey Into Wellness Counseling Services LLC or Julie Wells LCSW, CP. 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, one year from the date it is signed, on the following date:_____or as otherwise indicated:_____

Conditions
I further understand that Journey Into Wellness Counseling Services LLC or Julie Wells LCSW, CP 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.

_____
Signature of 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.).

_____
Signature of Therapist/Witness Date