Melissa Wilson, M.Ed., LMHC
Breathe to Believe Wellness

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HIPAA Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Release From: _____ Release To: _____

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

GENERAL AUTHORIZATION: I authorize **Melissa Wilson, LMHC** to release the information specified below to the organization/agency/individual named on this request. Method of release shall be pertinent to the need, and may include photocopies, fax copies, personal review, audio, video, electronic or verbal communication by the appropriate practitioner. I understand that **Melissa Wilson, LMHC** may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that, except for drug and alcohol treatment records, information disclosed under this authorization may be redisclosed by the recipient and is no longer protected by privacy laws.

SPECIFIC AUTHORIZATION: I specifically authorize the release of information regarding the following conditions:

_____ Alcohol/Drug abuse information- I understand that chemical dependency records are protected under the federal regulations governing Confidentiality of Alcohol and Drug abuse Patient Records, 42 CRF, Part 2, and cannot be disclosed without my consent unless otherwise provided for in this regulation (see below for disclosure prohibition).

_____Psychosocial/Psychotherapy information, to include background and diagnostic information, treatment progress and plan, progress notes, or assessment reports.

Other_____

INFORMATION REQUESTED:

_____Complete coy of medical record

_____History and physical exam

_____ Discharge Summary

_____ Diagnostic and treatment information relevant to patient's care

Other_____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

_____ Further Evaluation or Treatment

_____ Coordination of care with other healthcare providers

Other: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Without my previous expressed revocation, this authorization will automatically expire 1 year after the date of my signature below. In accordance with 42 C.F.R. Section 2.13, any disclosure of information from a federally assisted drug or alcohol abuse program must be limited to that information which is necessary to carry out the purpose of the disclosure. Pursuant to 42 C.F.R Section 2.32, the following statement on the prohibition of redisclosure must accompany each disclosure made with the patient's written consent.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R Part 2). The Federal rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute and alcohol or drug abuse patient

Patient Signature: _____ Date: _____

Parent/guardian signature (if patient is under 18): _____

Date: _____