intuition
wellness center
LEARN. GROW. THRIVE.

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AUTHORIZATION FOR RELEASE OF INFORMATION

*(Minor Client) I,*_____*, Parent/Guardian of*_____*, whose Date of Birth is* _____
Parent/Guardian Name *Minor Client's Name* *Minor's DOB*

*(Adult Client Only) I,*_____*, whose Date of Birth is*_____

Authorize Intuition Wellness Center, PLLC to disclose to and/or obtain from _____ *who can be*

contacted by ☐ *phone* _____ ☐ *email* _____ *the following information:*

[ ] Assessment	[ ] Educational Information	[ ] Billing & Scheduling
[ ] Diagnosis	[ ] Discharge/Transfer Summary	[ ] Progress in Treatment
[ ] Treatment Plan	[ ] Psychological Assessment	[ ] Current Treatment Update
[ ] Medication	[ ] Presence/Participation in Treatment	[ ] Medical Information
[ ] Psychiatric Report	[ ] Toxicological Reports/Drug Screen	[ ] Other _____

PURPOSE

*The purpose of this release is to improve assessment/treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services. If there is another purpose, specify:*_____.

EXPIRATION

Unless sooner revoked, this consent expires at termination of treatment. I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Intuition Wellness Center, PLLC.

CONDITIONS

I further understand that Intuition Wellness Center, PLLC 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 impair the ability to improve assessment and treatment planning and coordinate treatment services.

FORM OF DISCLOSURE

Unless you have specifically requested in writing that the disclosure be made in a certain format, Intuition Wellness Center, PLLC reserves the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records upon request.

I UNDERSTAND THAT MY TYPED NAME BELOW REPRESENTS MY ELECTRONIC SIGNATURE.

Minor Name/Adult Client Name	*Signature of Adult Client Only*	*Date*
Parent/Guardian Name	*Signature of Parent/Guardian*	*Date*
Parent/Guardian Name	*Signature of Parent/Guardian*	*Date*
Staff Witness Name	*Signature of Staff Witness*	*Date*

☐ *Check here if client declined to sign authorization.*