intuition wellness center
LEARN. GROW. THRIVE.

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Authorization for Release of Information
Behavioral Health & Psychological Testing

Section I. Client Name: _____ ***Client Date of Birth:*** _____

The above-named client, or their parent/guardian, hereby authorizes Intuition Wellness Center, PLLC, and its employees and representatives to release and disclose and/or request and obtain the Client's Protected Health Information ("PHI") as directed in the following sections:

Section II. Person/Entity Who Can Receive and/or Disclose Protected Health Information

Name: _____

Organization/ Institution: _____

Address: _____

Phone: _____ **Fax**: _____ **Email:** _____

Relationship to Client: ☐ PCP ☐ Psychiatrist ☐ Educator (e.g., Teacher) ☐ Parent

☐ Stepparent ☐ Grandparent ☐ Nanny/Caregiver ☐ Other: _____

Section III. Type of Disclosure Authorized (check all that apply)

☐ Release records from Intuition Wellness to person/entity identified in Section II.

☐ Request records from person/entity identified in Section II to be released to Intuition Wellness.

☐ Communicate with person/entity identified in Section II (no records released or requested).

☐ Presence and participation in sessions of person identified in Section II.

Section IV. Records/Information to Be Disclosed (See also Section V, below)

☐ Complete Health Record including Billing & Scheduling

☐ Complete Health Record excluding Billing & Scheduling

☐ Diagnosis

☐ Billing, Scheduling & Attendance

☐ Other (e.g., Treatment Summary): _____

Section V. Complete Health Record: Exclusions from Disclosure; Attendance/Presence in Sessions

Complete Health records may include all records and/or information as deemed necessary or appropriate in the professional discretion of your clinical team member, including without limitation, diagnoses, treatment plans, progress notes, evaluations and psychological assessments, unless expressly excluded. Prior to any disclosure, third party attendance or participation, I must discuss with my clinical team member any and all PHI to be excluded from disclosure. Health records do not include records, documents and reports of third parties.

Section VI. Purpose of Request

☐ Personal ☐ Continuity of Care ☐ Treatment ☐ Insurance ☐ Legal ☐ Change of Provider

☐ Other:_____

Section VII. Duration of Authorization/Expiration

This Consent is valid until the earlier of the occurrence of: (a) written revocation received by Intuition Wellness; (b) termination of treatment; (c) or the following date: _____ / _____ / _____.
Month Day Year

Section VIII. Miscellaneous

Form of Disclosure: Unless you have specifically requested in writing that disclosure be made in a certain format, Intuition Wellness 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.

Conditions: I understand that Intuition Wellness 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.

Fees: In the event that requested records cannot be sent electronically, I understand that I will be responsible for a $10 administrative fee plus the cost of postage.

I UNDERSTAND THAT MY TYPED NAME BELOW IN THE SIGNATURE LINE REPRESENTS MY ELECTRONIC SIGNATURE.

In the case of a minor, all parents/legal guardians are required to sign and date with time this document for Authorization to be valid.

Relationship to Client: ☐ Self ☐ Parent ☐ Guardian

Printed Name

Signature

Date/Time

Relationship to Client: ☐ Parent ☐ Guardian

Printed Name

Signature

Date/Time