

Authorization For Release of Information Psychiatric Clinical Services

Section I. Client Name: _____ **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).

Section IV. Records/Information to Be Disclosed

Lab Reports Chart Notes Diagnosis Billing, Scheduling & Attendance

Other: _____

Section V. Exclusions

Prior to any disclosure, I must discuss with my clinician any and all PHI to be excluded. Medical records do not include records, documents and reports of third parties. Exclusions (e.g., diagnosis, gender identity, etc.):

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

Relationship to Client: Parent Guardian

Printed Name

Printed Name

Signature

Signature

Date/Time

Date/Time