



## Authorization for Release of Protected Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize Weavings Wellness Group to:

RELEASE my protected health information TO:

RECEIVE my protected health information FROM:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Purpose of Disclosure:

At My Request  Disability Benefits  Other: \_\_\_\_\_

Information To Be Released:

Assessment Results  Psychotherapy Notes  Drug and/or Alcohol Treatment

Other: \_\_\_\_\_

Expiration:

For \_\_\_\_\_ Months  For 1 Year  Specific Date: \_\_\_\_\_

This authorization can be canceled at any time in writing to Weavings Wellness Group, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. Weavings Wellness Group cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_