

**Wellness Solutions, LLC**  
**Consent to Release Information of Confidential Information**  
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH**  
**INFORMATION**

*\*\*Please print, fill out if applicable, sign at the bottom, and bring to your first session. If you have any questions please let me know and we can discuss them in your first session.*

1. Client full name: \_\_\_\_\_ (Print)
2. **Date of Birth:** \_\_\_/\_\_\_/\_\_\_
3. **Social Security Number** \_\_\_\_\_
4. **Date authorization initiated:** \_\_\_/\_\_\_/\_\_\_
5. **This Authorization will expire on** \_\_\_/\_\_\_/\_\_\_.
6. **Authorization initiated by:** \_\_\_\_\_.
7. **Purpose of Disclosure:** The reason I am authorizing release is:  
\_\_\_\_\_.

8. **Person(s) Authorized to Make the Disclosure:** Wellness Solutions, LLC, staff, and therapists.

9. **Person(s) Authorized to Receive the Disclosure:** (Print)

Company: \_\_\_\_\_

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

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

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

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

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

10. **Information to be Released:** (Check)

- Assessment
- Progress Notes
- Attendance
- Other: \_\_\_\_\_.

11. **Information/disclosure is to be made in what format:** (Check)

- In-person
- Phone
- Written
- Other: \_\_\_\_\_.

**Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature of the Patient:** \_\_\_\_\_.

**Signature of Personal Representative:** \_\_\_\_\_.

**Relationship to Patient if Personal Representative:** \_\_\_\_\_

**Date of signature:** \_\_\_\_\_.

Wellness Solutions, LLC Witness: \_\_\_\_\_.

Wellness Solutions, LLC Witness Date of Signature: \_\_\_\_\_.