CONSENT FOR RELEASE OF RECORDS AND USE AND DISCLOSURE OF SUPER CONFIDENTIAL PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize Wellness Solutions, LLC, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ Assessment and diagnosis information regarding mental health, substance abuse, and any other reported diagnosis

☐ For unrestricted disclosure of information of the entire record for mental health and/or substance abuse treatment

☐ Information required for coordination of care of outpatient providers for mental health and/or substance abuse treatment/psychotherapy

☐ Information pertaining to client safety or public safety (Regardless of diagnosis)

☐ Information necessary for coordination of care with support system, family, and emergency contacts.

☐ Psychotherapy Treatment Notes and/or information within said notes

☐ Symptom report, management, and progress

☐ Treatment planning and coordination

☐ The dates of this approved disclosure are from: _____ to date: _____.

☐ **The provider may use this consent to release information from admission until three months post discharge.**

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original. Wellness Solutions, LLC reserves the right to discriminate the disclosure of materials and information in the client's chart even when provided with the permission to disclose information.

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical/psychotherapy records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, or any other form of communication, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ **HIV records (including HIV test results) and sexually transmissible diseases**

☐ **Alcohol and substance abuse diagnosis and treatment records**

☐ **Psychotherapy records**

REQUIRED TO COMPLETE:

In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: _____ (Name of Third Party)

3. For physical disclosure the records will be obtained by:
   _____
   Please allow _____ to pick up a copy of my records

   ☐ Third Party will pick up a copy of my records on or after this date: _____

   ☐ Send Third Party a copy of my records to this address: _____
   _____

4. **This disclosure is authorized by means of the following communication: (Please Check).**
   ___ In-Person ___ Phone ___ Email ___ Mail ____ Other Electronic Communication

By Patient: _____ **Date:** _____
(Print name)

By Patient: _____ **Date:** _____
(Signature)

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority)

By Patient's Representative _____ Date: _____
(Provide Signature)

Wellness Solutions, LLC Representative _____ Date: _____
Print name, sign, and describe authority)