



PLEASE INITIAL ON EACH LINE THAT APPLIES

Wilson Counseling

LIFE CAN BE GOOD

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME: _____

CLIENT DOB: _____

I hereby authorize release of the following information (Initial all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Medical Evaluation | <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Psychiatric/Psychological Evaluation |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Consultations | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |

FROM _____ **TO (initial one or both) Wilson Counseling, LLC**

FROM _____ **TO (initial one or both) the following:**

- | | |
|---|--|
| <input type="checkbox"/> DCBS Protection & Permanency | <input type="checkbox"/> DCBS Family Support |
| <input type="checkbox"/> Dept. for Juvenile Justice | <input type="checkbox"/> LifeSkills |
| <input type="checkbox"/> District/Family Court | <input type="checkbox"/> Board of Education _____ (County) |
| <input type="checkbox"/> Attorney: _____ | <input type="checkbox"/> Guardian Ad Litem |
| <input type="checkbox"/> Psychiatrist: _____ | <input type="checkbox"/> Other _____ |

Purpose of Release:

- Coordinate in treatment At request of the undersigned Other: _____

I understand and agree that this Authorization will be valid until 60 days after last date of service or revoked by client.

I understand that I can revoke or cancel this Authorization at any time by sending a letter to Wilson Counseling. If I do, it will prevent any releases after the date received but cannot undo that some information may have already been released. I understand that if the person/entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may no longer be protected by those regulations.

I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Wilson Counseling, nor will it affect my eligibility for benefits.

I understand that I may inspect and have 1 free copy of the health information described herein.

I acknowledge that I was offered a copy of this completed Release of Information.

Signature and Printed Name of Client/Guardian/Representative

Date

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