Psychiatric Alternatives & Wellness Center

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Authorization for Release of Protected Health Information

I hereby authorize: _____

Address: _____

Phone: _____ Fax: _____

to exchange information with my PAWC clinician, _____ , about my care.

Send my records via: ( ) FAX ( ) MAIL -- OR ( ) FILE WITHOUT SENDING

Records Pertaining to:

PATIENT NAME: _____

DATE OF BIRTH: _____

Check Information to be Released:

( ) Patient's mental health treatment plan and attendance
( ) Patient's mental health diagnosis
( ) Patient's psychiatric and psychology treatments (Psych Eval, Progress notes, Medications)
( ) Patient billing information
( ) Information relevant to coordinating care
( ) HIV/AIDS test results
( ) Other _____

( ) Limitations on this disclosure: _____

Dates of treatment:

From: _____/_____/_____ Through: _____/_____/_____ OR ( ) Duration of treatment

Purpose of this release:
( ) Psychiatric and/or psychological evaluation, diagnosis, and treatment planning-including risk assessment and safety planning
( ) Coordination of care
( ) Transfer of care
( ) Other: _____

This authorization is valid for _____ days from the date signed below. I understand that I can withdraw this consent at any time by submitting a written request. If no date is indicated, this authorization will expire 24 months after the date on which this form was signed. This information is confidential and further disclosure by the receiving party is prohibited without written consent. I have read and understand the above statement. I release Psychiatric Alternatives and Wellness Center of all legal liability that may arise from this disclosure.

Patient (or Parent/ Guardian) Signature: _____ **Date:** _____/_____/_____