HERITAGE
Counseling and Wellness
PLLC

www.heritagecw.com
910.240.4599

Authorization For Release of Information

Client Name: _____

Client's DOB: _____/_____/_____

I, the below signed, hereby authorize _____ of Heritage Counseling

and Wellness, PLLC. to disclose and/or obtain from:

_____(Name of Person or Organization)

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, and coordinate treatment services and shall include only that of the nature and to the extent specified below.

Check all that apply:

____ Psychological or Psychiatric Evaluation
____ Medical History
____ Current Treatment Update or Summary
____ Medication Management Information
____ Nursing/Medical Information
____ Educational Information
____ Legal History
____ Other_____

Specific Purpose:
_____

This authorization shall remain in effect for an unlimited amount of time, unless otherwise noted here: _____/_____/_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to info@heritagecw.com. However, your revocation will not be effective to the extent that your therapist has already made disclosures upon your prior consent. Should you wish us to take any additional action regarding this release of information, please send a separate letter regarding this request. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____

Signature of Patient (or Client's Guardian or Agent)

_____

Date

This is strictly a confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.