**Client’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**:

**First Middle Last Name**

**Address:**

**Date of Birth**: \_\_\_/\_\_\_/\_\_\_ **Phone#:**

**I Authorize Living Well, to release to and/or receive from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name/Title** **Agency/Organization**

**Phone# :**

**Address** (City, State, Zip)

**The following records and/or Information:**

\_\_\_\_\_\_ Psychological /Psychiatric \_\_\_\_\_\_ Military

\_\_\_\_\_\_ Therapy / Counseling \_\_\_\_\_\_ Medical

\_\_\_\_\_\_ Employment \_\_\_\_\_\_ Drug/Alcohol

\_\_\_\_\_\_ Educational \_\_\_\_\_\_ Evaluation/Reports

\_\_\_\_\_\_ Social History \_\_\_\_\_\_ Other(specify\_\_\_\_\_\_\_\_)

**The purpose of releasing/exchanging information is:**

**\_\_\_\_\_\_ To contribute to evaluation /assessment**

**\_\_\_\_\_\_ To assist with treatment planning**

**\_\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

|  |
| --- |
| **I understand that any records disclosed by Living Well, under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. All records received by the Living Well will remain confidential and will not be disclosed except as provided in this release. I further understand that Living Well cannot make any decisions regarding treatment, payment, enrollment, or eligibility for benefits based on this authorization. I permit this authorization for one year for the date of signature. I understand for one year from the date of the signature. I understand this authorization may be revoked at any time by providing written notice to Living Well. I understand a copy of this release is as valid as the original. This authorization will expire on the following date or event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Printed Name of Client**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature: \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Legal Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Witness:**