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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I,_____hereby authorize Garcia's Family Wellness Clinic, LLC
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

☐ HIV/AIDS related treatment ☐ Mental health information ☐ Psychotherapy notes

☐ Sexually transmitted diseases ☐ Drug/alcohol diagnosis, treatment/referral

to _____, _____
(receiving Agency/person) (Address, City, State, Zip Code) for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid for 12 months unless specified here:_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

Initial here if you chose to sign electronically below_____.

_____ _____ _____
Adult Client Name or Legal Guardia/Parent Name Signature of Adult Patient or Parent Date

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.