Willow Tree
THERAPY CENTER

Request/Authorization to Release Confidential Records and Information

Patient Name:_____ Date of Birth:_____Phone:_____

Address:_____ City, State, Zip:_____

I hereby authorize _____to (Check one or both)

❑ Send and/or ❑ Receive copies of your record to (or discuss information with):

Name of Provider/Person/Facility	Address	
City, State, Zip	Phone	Fax

Purpose of this Request:

❑ At the request of the patient/guardian ❑ Coordination of services ❑ Other: _____

Type of Records or Information Requested:

❑ Intake and/or Discharge Summary ❑ Psychiatric Evaluation ❑ Medical History and/or Evaluation(s)
❑ Treatment Plan(s) ❑ Presence/Participation in Treatment ❑ Medication Management Information
❑ Other: _____

For the following dates of service:_____

I have a right to inspect a copy of any and all materials that I authorized to be disclosed. I understand that my records are protected under federal, state, and local regulations governing confidentiality and privacy of my treatment information, included but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent in writing at any time, except to the extent of actions that have already been taken in reliance on it. Further, I understand that disclosure of information to individuals or entities that are not covered by HIPPA regulations, such as parents, spouses, children, significant others, is not protected by HIPPA prohibitions on disclosures.

This consent expires:

❑ One year from the date of this consent, or ❑ On the following date, event, or condition: _____

Patient Signature	Printed Name	Date
Guardian/Responsible Party Signature	Relationship to Patient	Date
Witness Signature	Printed Name	Date

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