Authorization for release of Protected Health Information

Living Tree Wellness Center, LLC

I, _____[Client Name], authorize Marlena Johnson to disclose to and/or obtain from: _____[Recipient] the following information: Phone and/or Address:_____

Description of Information to be disclosed (INITIAL each item to be disclosed)

_____ Diagnosis

_____ Psychological Assessment

_____ Treatment Plan

_____ Presence/Participation in Treatment

_____ASAM/Substance Abuse Treatment

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

_____Other_____

_____Other_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than as specified above, please specify:

_____

I understand that I have a right to revoke this authorization, in writing, or verbally, at any time. Unless sooner revoked, this authorization will expire 90 days after treatment is complete.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I have been offered a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Printed name of above signed