AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

I, _____, authorize Monarch Wellness to release to/from:
(Client or Legal Guardian)

_____

_____
(Name of Individual/Organization and Address/Phone Number/Fax Number)

_____Information from client records of: _____ (Name)
(Initial) _____ (Date of Birth)

_____For the following purpose, use, or need:_____
(Initial)
_____

The information from these records may be disclosed, covering the dates from:
_____ to _____.

Exclude the following information from disclosure:_____
_____

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of my therapist at Monarch Wellness and any information previously authorized and released will not be subject to revocation. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. The released information may not be copied, shared, or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Monarch Wellness will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature. I have also had the opportunity to have this form explained to me and have my questions answered.

_____ _____
Client (Please print) Client Signature

_____ _____
Parent/Guardian if minor (Please print) Parent/Guardian Signature

_____ _____
Witness (Please print) Witness Signature

Date:_____