WAYFIND COUNSELING LLC

Authorization for Release of Information

Client's name: _____Date of Birth_____

I authorize Kimberly Bechtel LMHC, ATR of Wayfind Counseling LLC to:

☐ Release to ☐ Receive from ☐ Both Release and Receive

The following information:

- ☐ Medical history, evaluations, diagnoses and recommendations
- ☐ Mental health evaluations, diagnoses, and recommendations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes
- ☐ Treatment or discharge/termination summary
- ☐ Other

To or from the following person, business, or agency. (Please include the contact information for the entity whom information is to be received from or released to)

Entity/Individual Name: _____
Phone: _____ Fax: _____
Address: _____
City:_____State:_____Zip:_____

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Supporting Documentation for other services at client request
- ☐ Coordination of ongoing care between providers
- ☐ Other: _____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records,

Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature:_____ Date: _____

Relationship to client: _____
(Self, Parent/legal guardian, Personal representative, Other)

Witness: _____ Date: _____
(Wayfind Counseling LLC Staff, Clinician, or Notary)