WELTITUDE PSYCHOLOGY
FIND YOUR CALM. RESTORE YOUR WELLNESS.
Michigan & Texas

(512) 222 - 4686
therapy@weltitudepsychology.com
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Business Information

Weltitude Psychology, PLLC
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Authorization to Release/Obtain/Exchange Confidential Information

INSTRUCTIONS:

In order for your provider and/or Weltitude Psychology, PLLC to release, obtain, or exchange confidential information, this authorization must be completed according to these instructions. All information related to identification, location, and communication of those involved in the release of information must be provided. This is necessary to ensure that information is released only to those you intend. For your protection, if this form is incomplete, we will not release or request the release of any information OR you may be asked to complete the form again. If you need assistance in completing this form, contact Weltitude Psychology, PLLC at 512-222-4686.

I,

Client Legal Name - First Last

Date of Birth

Social Security No.

CLIENT STREET OR MAILING ADDRESS

CLIENT CITY/STATE/ZIP

CLIENT PHONE

AUTHORIZE my provider:

Therapist Name

and/or the clinical or administrative staff at Weltitude Psychology, PLLC to

Select all that apply

- ☐ Release or Disclose Confidential Information To
- ☐ Obtain Confidential Information From
- ☐ Exchange Confidential Information With
- ☐ Release to Myself

Release or Disclose Confidential Information To:
Authorization is to release or disclose information only to the identified sources listed below.

Obtain Confidential Information From:
Authorization is to obtain information from another source that is listed below.

Exchange Confidential Information With:
Authorizes the two designated parties to share information. This option provides the greatest flexibility for communication.

Release to Myself:
To individual client for use at their own discretion.

*Note, if releasing information to yourself, please insert your information below.

NAME OF PERSON/ORGANIZATION/FACILITY

STREET OR MAILING ADDRESS

CITY/STATE/ZIP

PHONE

FAX NUMBER

The confidential information to be disclosed, released, exchanged, or obtained is:

Select all that apply:

- ☐ Assessment Summary and Recommendations

If 'Other' Please Specify Here:

- [ ] Diagnosis or Diagnostic Impression
- [ ] Psychological Evaluation Report
- [ ] Treatment Plan or Summary
- [ ] Current Treatment Update or Progress in Treatment
- [ ] Presence/Participation in Treatment
- [ ] Continuing Care Plan or Mental Health Maintenance Plan
- [ ] Progress or Psychotherapy Notes
- [ ] Date(s) of attendance and type(s) of services received
- [ ] My entire record
- [ ] Information regarding mental health
- [ ] *Other, Please Specify

The purpose of releasing, disclosing, exchanging, or obtaining the confidential information is for:

Select all that apply

If 'Other' Please Specify Here:

- [ ] At my request (Request of the client)
- [ ] Participation of a family member or other person(s) in treatment
- [ ] Legal proceedings or matters
- [ ] Disability accommodations or benefits
- [ ] Continuity of care or collaboration of care with other healthcare professionals
- [ ] Other *Please Specify

Restrictions or limitations, please specify here:

(Please Specify)

Unless sooner revoked, this authorization expires:

Select One

If 'Other' Please Specify Here:

- ○ One time (i.e., after purpose of this authorization is completed as outlined in this document)
- ○ Thirty (30) days after the date of authorization.
- ○ Sixty (60) days after the date of authorization.

- ○ Six (6) months after the date of authorization.
- ○ One (1) year after the date of authorization.
- ○ Other *Please Specify

Form of Disclosure, Release, or Exchange of confidential information

If you desire, you may limit the disclosure, release, or exchange of your confidential information to one of the following methods:

Choose One

- ☐ No preference of method of disclosure
- ☐ Verbal
- ☐ Written
- ☐ Electronic
- ☐ Fax
- ☐ Other (please specify):

If other, please specify:

By signing below, I acknowledge and understand the following:

The matters discussed on this form.

I release Weltitude Psychology, PLLC from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I have the right to revoke this authorization, in writing, at any time by sending written notification. Revocation is not effective for disclosures already made in reliance on this authorization.

My provider and Weltitude Psychology, PLLC will not condition treatment on whether I sign this authorization.

Authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment unless the sole purpose of the treatment is to disclose information for which this authorization is necessary.

I may inspect or obtain a copy of the information to be used or disclosed as provided by federal regulations (see 45 CFR §164.524: https://www.ecfr.gov/).

Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, unless state law provides greater protection.

Weltitude Psychology, PLLC cannot guarantee confidentiality of information after it is released.

Signature of Client:

Date of Authorization

mm/dd/yyyy

Client Legal Name - First, Last

Date of Birth

Client Address

Office Use Only

Review by:

Therapist's Name:

Today's Date:
mm/dd/yyyy

Provider signature:

Use your mouse (or, on a touch device, your finger) to draw your signature in the box above.