Authorization for Release of Information

Name_____DOB_____/_____/_____

I authorize Wendy Reimann, LMFT, LPC to use and disclose a copy of the specific health information described below and I authorize and exchange of the confidential specific health information between Wendy Reimann, LMFT, LPC and:

Name:_____
Address:_____
Phone:_____

This information will be used on my behalf for the purpose(s) of:_____
_____

By initializing below, I specifically authorize the release of the following medical records:

___Chart Intake and Progress Notes
___Mental Health Services Summary
___All records needed for continuity of care
___Drug/Alcohol Diagnosis, Treatment, Referral
___HIV/AIDS Information
___Medical History & Physical Assessment
___Psych Evaluation / Testing Information
___Other

I understand that the information used or disclosed pursuant to this authorization may be subject to and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that I do not need to sign this authorization and that refusal to sign will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign prohibits receiving health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Unless revoked earlier, this authorization will be in effect for the duration of my treatment with Wendy Reimann, LMFT, LPC. I may revoke this authorization at any time by a written request to Wendy Reimann. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has already taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. My signature indicates that I understand the above and consent to disclose indicated information.

_____ _____
Individual or Personal Representative Signature Date

Personal Representative authority: _____

To those receiving information under this authorization: This information is protected by State and Federal Law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

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