AMAR Wellness Services, LLC

AMARWELLNESS.COM

RELEASE OF INFORMATION AUTHORIZATION

I, _____[Client Name], whose Date of Birth is _____, authorize AMAR Wellness Services, LLC to disclose to and/or obtain from:

_____[Name/Title of Person/Organization] the following information:

Description of Information to be Disclosed

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____

Purpose
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.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to AMAR Wellness Services, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires on the following date: _____.

Conditions
I further understand that AMAR Wellness Services, LLC will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure
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.

Redisclosure
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.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative (circle one) Date

(modified with permission from National Association of Social Workers: Popovits & Robinson, P.C. 2013)

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