Resolutions Therapy
Individual, Couple & Family Therapy

Authorization for Release/Disclosure of Information

Client:_____ Date of Birth: ____/____/_____

I, _____ , hereby authorize Resolutions Individual, Couple & Family Therapy, LLC, to:

☐ ***Obtain*** protected health information from the facility/provider named below
☐ ***Exchange*** protected health information with the facility/provider named below
☐ ***Disclose*** protected health information to the facility/provider named below

_____/_____ _____
Name of Facility/Provider Telephone

_____ _____
Address Fax

Type of Information to be Disclosed/Obtained/Exchanged:

☐ Psychological Testing Results ☐ Treatment Summary ☐ Diagnosis
☐ Alcohol/Substance Use ☐ Medication(s) ☐ School/Education Records
☐ Hospital Records ☐ Appointments Kept ☐ Financial & Billing Only
☐ Other: _____

Purpose of Release:

☐ Coordination of Treatment ☐Other: _____

Release Format(s):

☐ Verbal Communication ☐ Written ☐ Electronic Media (Fax) [*for urgent needs only*]

Expiration Date:

☐ 365 days from date signed ☐ Other (specify event): _____

I can revoke this authorization by sending written notification to Resolutions Individual, Couple & Family Therapy, LLC, 807 N Waco Ave, Ste 12, Wichita, KS 67203. Any revocation made will not be retroactive to any prior confirmed authorizations other than as a condition for obtaining insurance coverage if/when the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule.

I have read and understand the above information and give my authorization voluntarily.

_____ ____/____/_____
Client Name / Signature Date

_____ ____/____/_____
Witness/ Signature Date