Release of Information

The purpose of this form is to authorize the parties indicated to disclose and exchange client information to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with Kendra Wilson, LCSW. The original of this form will be placed in your record and a copy may be sent to other parties.

I, _____ (client name), authorize Kendra Wilson, LCSW to exchange the specified information for the purpose of coordinating care. I understand that:

- I have the right to be told and to review the information being exchanged.
- Information may be exchanged via a variety of communication forms (including but not limited to: phone, fax, email, tele-health, electronic medical record sharing, or in person).
- This information will only be disclosed to parties specifically indicated, at which time those parties are responsible for maintaining the privacy of your information. Please be aware that if this information is disclosed to the court, it may be made part of the court record and therefore available to the public by federal and state law.
- I may refuse or revoke my consent at any time by writing a letter to Kendra Wilson, LCSW. I understand that the revocation will not apply to any information already used or disclosed under this authorization.
- This consent will be valid for one year following conclusion of treatment with Kendra Wilson, LCSW, unless otherwise indicated.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment with Kendra Wilson, LCSW, nor will it affect my eligibility for benefits.
- We will protect your confidentiality by providing the minimum necessary PHI to any third-party request.
- For further information regarding privacy practices, please see you "Rights and Consent to Treatment" and "Notice of Privacy Practices" given to you at the time of intake.

Company/Individual Information - Name Phone/Fax/Address/Email/Other

_____

_____

_____

The following information may be shared: (check all that apply)

_____ Attendance (including cancellations)
_____Billing records
_____Diagnosis(es) (current and/or past)
_____Discharge Notes/Summaries
_____Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
_____ Intake and/or bio-psycho-social history, reports, assessments, treatment notes, summaries
_____Medications (current and/or past)
_____Progress or similar notes
_____Recommendations
_____Treatment, recovery, rehabilitation, aftercare plans and other similar plans
_____Complete copy of the medical record (excludes psychotherapy notes)
_____Psychotherapy notes/records
_____Other: _____

Signature: _____ Date: _____
(of client or representative) *for:*
Name (print): _____ Date of Birth: _____
& relationship to client (if representative)