Hope Wilson, PCC, LICDC
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I hereby authorize Hope Wilson, PCC, LICDC

please initial desired action(s) ___ release to

___ exchange with

___ request from

the individuals or facilities set forth below. This authorization also authorizes Hope Wilson, PCC, LICDC to discuss these matters with those individuals or the personnel of those facilities. A photocopy or facsimile copy of this instrument likewise shall be valid for such purposes.

Your information:
Re: Client Name_____

Date of Birth_____

Facility _____ Contact Person_____

Address_____

City/State/Zip_____

Telephone_____Fax_____

___ All psychological, diagnostic, treatment, and other health care information
___ All information pertinent to comprehensive treatment planning
___ Social history
___ Treatment summary
___ Observations and recommendations
___ Results and interpretations of psychological testing
___ School records and impressions
___ Medical evaluations and impressions
___ Other: _____

Parent Name (if minor) (print) _____

Social Security Number_____

Date of Birth_____

Address_____

City/State/Zip_____

Telephone (day)_____(evening)_____

This consent to disclose may be revoked by me in writing at any time except for information that has already been released in accordance with this authorization.

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release.

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any disclosures after the date it will be received but cannot change the fact that some information may have been sent or shared before that date.

I understand that if this person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release.

(Signature of client or person authorized to consent) (date)

(Printed name of client or person authorized to consent) (date)

(Relationship to client)

(witness) (date) (time)

EXTENSIONS

(Signature of client or person authorized to consent) (date)

(witness) (date) (time)

(Printed name of client or person authorized to consent) (date)

(witness) (date) (time)