Wellsprings
PSYCHOLOGICAL RESOURCES®

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Authorization to Obtain and/or Exchange Information

Client's Name: ____ **Date of Birth**: ____/_____/________
MM DD YYYY

Parent/Legal Guardian (for minors): __________________________________ **Relationship**: _________________

I hereby authorize Wellsprings Psychological Resources

To: ☐ **OBTAIN information FROM:** and/or ☐ **EXCHANGE information WITH:**

Individual/Agency: ____

Mailing Address: ____

Phone Number: (_____) ______-_________ **Fax Number**: (_____) ______-_________

I authorize the release of the following information:

☐ **Psychiatric/Psychological** (including diagnosis, assessments, treatment plans, current and/or past treatment progress, medication history, recommendations, and dates of service/attendance record)
☐ **Medical** (includes results of past medical assessment, treatment, treatment results, and recommendations)
☐ **Educational** (including attendance, conduct, expulsions, special education assessment, social history, individual educational plans, progress in meeting educational goals, educational recommendations)
☐ **Child Welfare** (including incidents resulting in DFCS involvement, comprehensive assessments, service plans, progress on service plans, placement history, court reports, recommendations)
☐ **Legal** (Including arrest/conviction/probation history, probation/parole progress, detentions, recommendations)
☐ **Other** (please specify): _______________________

Purpose for release of information:

☐ **Coordination** of services with the above agency or individual
☐ **Consultation** with the above individual or agency for continuity of care and/or treatment planning
☐ **Transfer** of treatment
☐ **Other** (please specify): _______________________

I Understand that:

- Treatment, payment, enrollment, or eligibility benefits will not be conditioned on whether I sign this authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the practice.
  Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.
- This authorization will expire on ___/___/_____ OR 1 year from the date of this authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other state or federal laws.
- This authorization CANNOT be used to disclose Psychotherapy Notes.
- Once signed, the Practice may provide me with a copy of this Authorization upon request.
- A photocopy or Facsimile of this signed authorization form shall be considered as valid as the original.

I have had the opportunity to review and consider the contents of this authorization. By signing this form, I am confirming that the above information is correct.

____ ______/____/__________
Signature of client (or legal guardian/personal representative) Date

____
Printed name of client (or legal guardian/personal representative and his/her relationship to client)