Wellsprings
PSYCHOLOGICAL RESOURCES®

Office: 63 Springs Station Drive, GA 30639
Mail: P.O. Box 157, Franklin Springs, GA 30639
Phone: (706) 246-0733
Fax: (706) 246-0722

Authorization to Release Information

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

Parent/Legal Guardian: _____ **Relationship**: _____

I hereby authorize Wellsprings Psychological Resources

To: ☐ **OBTAIN information FROM:** **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 personal representative) Date

_____
Printed name of client (or personal representative and his/her relationship to patient)

_____
OFFICE USE ONLY: Wellsprings Staff Initial