WELLSPRING HEALING CENTER, LLC
psychology, yoga, healing

EMERSON DELACROIX, MACP, RYT-200, LLP | ROSE BENJAMIN, LMSW
704 N. CONGRESS ST. SUITE #3 YPSILANTI, MI 48197 | FAX: 734-573-6008
wellspringhealingcenter@gmail.com | www.wellspringhealingcenterllc.com

AUTHORIZATION OF DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's legal name: _____ Date of Birth: _____

I, _____authorize the information specified below to be disclosed as follows:

From/To **Wellspring Healing Center, LLC**
To/From: Name of person/organization: _____

Phone number: _(_____)_____

Address: _____

_____

Disclosure shall be limited to the following specified information contained in my records and/or obtained during the course of my treatment with a therapist at Wellspring Healing Center, LLC (WHC) (Check of YES or NO for each item):

	YES	NO
Assessment and Diagnostic Summaries	____	____
Psychiatric Evaluations	____	____
Medication Regime	____	____
Laboratory Information (Excluding HIV)	____	____
Attendance Record	____	____
Progress Note: Specify Dates _____	____	____
Verbal Exchange	____	____
Discharge Summary	____	____
Other: Please Specify_____	____	____

If information in my records pertains to HIV or AIDS, I expressly do____, do not____, authorize WHC to disclose such information pursuant to this authorization. PLEASE INITIAL_____ or Not applicable ____

I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release WHC, and its affiliates, representatives, and assigns, from all legal liabilities that may result from the release of this information. I acknowledge that I have the right to revoke this authorization at any time, by sending written notification to the medical records department of WHC. I understand that a revocation is not effective if WHC already has taken actions in reliance of the authorization.

I am requesting that this information be disclosed for the purpose(s) of: _____.

This authorization shall be in full force and effect until _____. If no expiration date is provided, this authorization shall expire one hundred eighty (180) days after the date on which I signed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.

I understand that will not condition my treatment, payment, or enrollment or eligibility for benefits on whether I provide this authorization.

_____ _____
Client signature/Legal guardian signature (if applicable) Date

_____ _____
Legal guardian name (print) Indicate Authority to Sign

_____ _____
Witness signature Date