

Wentworth & Associates, P.C.
Licensed and Certified Psychotherapists
Phone: 586-997-3153 Fax: 586-997-4956

Part I: Release of Information

1. I, _____ hereby authorize Wentworth and Associates, P.C. to disclose the following: *(check one or both if applicable)*:
- a. Release of written information to party named in section 2 below.
 - b. Consultation and verbal exchange of information between parties named in sections 1 and 2.

2. The action(s) described in item 1 (*above*) is(are) authorized to/with:

Fill in the name of the external individual, clinic, agency, hospital, school, or other to whom the information will be released. Provide complete address. If released to persons/organizations, attach an additional sheet(s), as needed.

3. Description of information authorized for release or consultation: *(The person signing may delete items by striking through items.)*
- a. complete provider clinical record, or date range(s) authorized for release from _____ to _____
 - b. Substance abuse/mental health assessment, recommendations, demographics and rationale for referral
 - c. statement of specific problems or disabilities (including reports on testing) and special needs
 - d. plan of service/diagnosis / prognosis/treatment needs/goals/progress notes
 - e. psycho-social history summary/treatment summary/discharge summary
 - f. other (specify) _____

4. For the purpose indicated of:
- a. to facilitate mental health/healthcare treatment or services and continuity of care
 - b. pursuant to legal action/inquiry: release to court, administrative agency, document service or attorney
 - c. consumer's application for benefits (e.g., SSI, etc.).
 - d. other consumer authorized purpose (specify)

Client Signature: _____ Date: _____ Witness: _____

Social Security #: _____ Date of Birth: _____

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME PRIOR TO RELEASE.

I understand that this authorization is voluntary. I understand that my records are protected under federal regulations including alcohol or substance abuse, as well as information protected under regulations in code 42, part 2, psychological service records, social service records, HIV communicable disease information, including communications between psychologist and you. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. **Wentworth and Associates, P.C. is released from all legal liabilities for the release of the above requested information.** This consent expires 6 months from information release date.

See reverse side for Dual Release of Information

Part II: Dual Release of Information

I further authorize _____ to release to Wentworth and Associates, P.C. the following information: confirmation of appointment(s), admission status, progress in treatment, discharge status, and/or health history, brain scan, MRI, PET or SPECT scan and/or other for the purpose or need to determine referral outcome or to aid in continuity of care. Specify other purpose below:

Client Signature: _____ Date: _____ Witness: _____

Social Security #: _____ Date of Birth: _____

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME PRIOR TO RELEASE.

I understand that this authorization is voluntary. I understand that my records are protected under federal regulations including alcohol or substance abuse, as well as information protected under regulations in code 42, part 2, psychological service records, social service records, HIV communicable disease information, including communications between psychologist and you. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. Wentworth and Associates, P.C., as well as former associates, are released from all legal liabilities for the release of the above requested information. This consent expires 6 months from information release date.