ACACIA
counseling and wellness

Consent to Release / Exchange Medical & Mental Health Information

Updated 11/21/2019

Client Name: _____ **Date of birth:** _____

I authorize Acacia Counseling & Wellness to release/exchange health and/or counseling information about me to:

Name: Relationship:

Address: Phone/Fax:

Specific type of information to be released and/or exchanged:

☐ Verbal ☐ Written ☐ Release only ☐ Receive Only

☐ **All relevant information**
☐ Diagnostic Assessment
☐ Progress Notes
Dates of service: _____ to _____
☐ Other reason: _____
☐ Discharge summary
☐ Telephone consultation
☐ Treatment Plan

I understand that the information is to be used for:

☐ Coordination of care ☐ Legal ☐ Personal ☐ Other reason:_____

NOTICE: Acacia Counseling & Wellness, and other health care providers and organizations such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing to each of the treatment providers listed above.

This release expires in one year unless another date is specified: _____

Provider: _____ _____
Signature Printed Name

Client: _____ _____
Signature Printed Name

Date: _____