WISDOM TRADITIONS
–COUNSELING SERVICES, LLC–

AUTHORIZATION FOR RECIPROCAL RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I_____,_____authorize Wisdom Traditions Counseling Services to:
(*Patient Name*) (*Date of Birth*)

_____release to: _____obtain from: _____exchange with:

_____ **Ph**: _____
(Name or general designation of individual or entity making the disclosure) **Fax**: _____

Chosen Delivery Method: ☐ **Patient Portal** **Fax:**_____ **Mail:**_____
☐ **Will Pick Up**

the following information pertaining to myself: ***(Please initial all that apply)***

_____Assessment Results
_____Psychological Test Results
_____Medical Evaluation/Medication History
_____Integrated Clinical or Psychiatric Evaluation/Medication History
_____other: _____
_____Treatment Summary
_____Dates of Attendance/Scheduling
_____Compliance with Treatment Recommendations
_____Family Program
_____Billing & Financial

for the purpose of: ***(Please initial all that apply)***

_____Evaluation/Assessment
_____Coordination of Treatment Efforts
_____Legal
_____other: _____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically in one year from the date of the signature unless otherwise stated below:

_____

Date, event, or condition upon which consent will expire, which must be no longer than reasonable necessary to serve the purpose of this consent, and not to exceed one (1) year.

This form cannot be used for the re-release of confidential information provided to Wisdom Traditions Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Person other than Patient Relationship of Person Date

_____ _____
Signature of Witness Date

_____ _____
Date Revoked Staff Initials

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RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____6 months OR

_____other (specify) _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

Check One:

_____6 months OR

_____other (specify) _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

401 W International Airport Rd Suite 17 99518 Ph: 907 562 4540 Fax: 907 562 4502