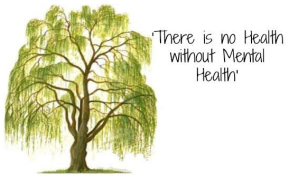
Willow Sage Services
Behavioral Health Clinic



Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I hereby authorize and direct **Willow Sage Services** to receive or disclose protected health information described below to the following person or entity.

TO: Person / Entity: _____

Address: _____

Phone: _____ Fax: _____

RE: Subject of Information Release (Client): _____

Date of Birth: _____ SSN: _____

Address: _____

Term of Authorization for Release of Information, all past, present and future periods **OR** the period from (date / event) _____ to (date / event) _____

The information to be disclosed is marked by an X below. Excluded information is lined-out.

- ☐ Mental health records, including DSM diagnoses.
- ☐ Medical records, including prescribed medications
- ☐ Current Medical History and Physical Examination
- ☐ Developmental and/or Social histories
- ☐ Treatment / Service plan
- ☐ Intake and discharge summaries
- ☐ Treatment or closing summary
- ☐ Personal observations
- ☐ Comprehensive Diagnostic Assessment, Functional Assessment, and/or Intake Assessment
- ☐ Records of drug and/or alcohol treatment are specifically **included** in this disclosure
- ☐ Other: _____

The following information is NOT included in this disclosure, and is not to be released:

- ☐ None.
- ☐ Other: _____

- This information may be used by Willow Sage Services, or its agents, for mental health evaluation, treatment, care or consultation, rehabilitation program development, or service, billing or other purposes I may direct in writing.
- This authorization shall be in force and effect for one year, or unless otherwise listed above at which time this authorization will expire as indicated above.
  I understand that I have the right to revoke this authorization, in writing, to the above address, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on this authorization.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that records obtained as authorized by this consent for information release will be maintained in accordance with Federal regulation, 42 CFR part 2, which prohibits re-disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. By law this facility is required to keep confidential all records, prognosis, or treatment of patients utilizing our services.

_____ _____

Signature of patient (14 and older), parent, guardian, or personal representative Date

_____ _____

Signature of parent (patient 17 or younger), guardian, or personal representative Date