Hamilton Wellness, PLC

A Bridge to Your Best Self

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Hamilton Wellness, PLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ Date of Birth:_____

Authorize Hamilton Wellness PLC to:

____**Release to:**

____**Obtain from**:

____**Exchange with:**

Name (Person(s) or facility)_____

Address_____

Phone_____

Fax_____

The following information:

___Treatment summary

___History/Intake

__Diagnosis

__Psychological Evaluation Material

__Dates of Treatment Attendance

__Other
(specify)_____

For the purpose of:

__Evaluation/Assessment

__Coordination of Care

__Other (specify)_____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time. (Except to the extent of information which has already been released.

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Signature of Witness Date