WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Authorization for Release of Information

I, _____, hereby authorize Waypoint Mental Health Counseling to release and/or obtain the following information in:

☐ my records ☐ my child's records: _____ _____
Child's Name (if applicable) Client's DOB

☐ Psychiatric records ☐ Medical related information ☐ School related information
☐ Psychological assessment ☐ DHS/Case Worker Reports ☐ Legal/Court documents
☐ Other: _____

This information is to be ☐ released to ☐ obtained from

Name of Individual/facility: _____

Contact Information: _____

This authorization will expire: ☐ 12 months ☐ other (specify date) _____

Information is being released for the following purpose: _____

Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re-disclosure by the recipient, resulting in the information no longer being protected. Services are not contingent upon the consumer's decision concerning authorization for the release of information.

I understand that my insurer requires certain information regarding treatment, I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the protected healthinformation related to mental health. Release of mental health records or psychotherapy notes may require the consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse treatment records. This specific category of medical information/record is protected by Federal law, (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further releases unless further release is expressly permitted by the written authorization of the client or is permitted by Federal Law, (42CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol/drug abuse client. The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease. As a result, by signing below, I specifically authorize any such records in my health information to be released.

Name of Client: _____ Name of Guardian: _____
(if applicable)

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)

Witness (Mental Health Professional): _____Date: _____