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**Authorization to Disclose Confidential Information**

I understand that **Leslie J Wondra LLC** has an obligation to keep my personal information, identifying information, and records confidential. I also understand that I can choose to allow **Leslie J Wondra LLC** to release some of my personal information to certain individuals or agencies.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB: \_\_\_\_ \_\_\_\_\_ \_\_\_\_) voluntarily authorize **Leslie J Wondra LLC** to: ⬜ **release to** ⬜ **receive from** or ⬜ **exchange with**

Name of agency or person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| the following information:  ⬜ **Intake Assessment**  ⬜ **Presence/Participation in Treatment**  ⬜ **Treatment recommendations**  ⬜ **Diagnostic Screenings**  ⬜ **Clinical progress notes**  ⬜ **Diagnosis**  ⬜ **Discharge Summary**  ⬜ **Treatment Plan**  ⬜ **Other (specify below)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | for the period of:  ⬜ **All dates of treatment**  ⬜ **Other (specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| for the purpose of:  ⬜ **Coordination of care**  ⬜ **Other (specify below)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_** |

This authorization is valid for one year from date of signature or expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand authorizing the use or disclosure of the information identified above is voluntary, I can refuse to sign.
* I understand that my treatment at **Leslie J Wondra LLC** is not conditional on my signing an authorization.
* I understand I have the right to revoke this authorization at any time by written request. However, my revocation will only apply to future disclosures and is not retroactive.
* I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.
* I understand that **Leslie J Wondra LLC**. will release only the minimum amount of information necessary to fulfill a request. Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
* I understand that I have a right to receive a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

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Signature of Therapist Date