Allow Your Well-being Group Practice LLC
1232 E. Wardlow Rd.
Long Beach, CA 90807
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# Authorization for Disclosure of Healthcare Information

Directions: Fill in the appropriate information in each applicable section. A separate authorization must be completed for each request.

**Client Full Name:**_____**Date of Birth:**_____

**Information to be released or exchanged between Allow Your Well-being and the following:**

_____

Phone Number:_____ Fax Number: _____
Address: _____City/State:_____ Zip Code:_____

**Purpose of Disclosure:** _____

**Items/Information to be released** (please initial all that apply):

____ **Complete Medical Record** (Covers all below)
____ History and Physical Report
____ Consultation Reports
____ Discharge Summary
____ Discharge Instructions/Medication Lists
____ Lab Reports
____ Emergency Room Report
____ Psychiatric Evaluation
____ Psychological Testing
____ Progress notes (NOT Psychotherapy notes)
____ Alcohol/Drug Abuse Treatment/Referral
____ HIV/AIDS Related Treatment
____ Sexually Transmitted Diseases
____ Other (Specify): _____

____ Psychotherapy Notes ONLY

IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.

PSYCHOTHERAPY NOTES ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES. IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

**I understand that:**

1. I may refuse to sign this authorization and that this is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it should not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
4. I may request a copy of this form after I sign it.
5. This form will expire in one year unless otherwise specified on this date: **Expiration Date**: _____

**SIGNATURES**

I have read the above information and authorize the disclosure of the protected health information as stated.

**Signature of Member/ Guardian/ Member Representative:**_____ **Date:** _____

If signed by person other than member, indicate relationship and authority to do so:
**Print Name of Member Representative:** _____
**Relationship to Member:** _____