Request/Authorization to Release Confidential Records and Information

Release From: Northern Wellness Counseling, LLC Phone Number: (907) 227-0029

Address: 517 W Northern Light Blvd, Anchorage, AK 99503

Release To: _____ Phone Number: _____

Address: _____

Client Name: _____

DOB: _____

Address: _____

Information to Be Released:

Type of Communication (please circle)

Verbal Written

Information to Be Released:

Intake and Discharge Summaries Mental Health Assessments Treatment Plans

Progress Notes Other: _____

For the Following Purpose(s):

Personal (at the request of client) Treatment Legal Other: _____

I understand that this request/authorization to release records and information is voluntary. I understand the nature of this request, the records, their contents, and the likely consequences and implications of their release. I understand that I may revoke this voluntary consent at any time before the end date. Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing. Unless revoked earlier, this authorization will expire one year from the date on which it was signed, or upon the following date or event: _____

I understand that once the above information is disclosed, it may be subject to re-disclosure by the receipt and no longer protected by federal privacy laws or regulations.

Signature of Client Printed Name Date

_____

Signature of Guardian Printed Name Date

_____