ADVANCED ▪ RELIABLE ▪ COMPREHENSIVE
Counseling and Wellness

Authorization to Release Confidential Information

Client's Name: _____ Date of Birth: _____/_____/_____

Information to be Released:

___Dates of treatment ___Diagnosis ___Financial Records ___Any and all information

___Other: _____

Purpose of Disclosure: _____

Person(s) Authorized to Make Mutual Disclosures:

1. ARC Counseling and Wellness Staff (909) 333- 7434
2. _____ Phone # _____

This Authorization will expire on ____/____/____ or upon my written termination of this authorization.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____
Printed Name of Client or Client's Representative

_____ _____
Signature of Client or Client's Representative Date