Dragonfly Wellness and Education Center

**Authorization to Release Information**

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Dragonfly Wellness and Education Center to:

* obtain from
* release to

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following documents from the records pertaining to services received from:

* \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_ OR
* all past, present, and future periods.

The documents to be released are described or listed as:

* + Identifying information
  + Intake / Evaluation / Diagnostic Summaries
  + Discharge / Exit Summary
  + Treatment plan and/or progress notes
  + Scheduling / attendance

The records are required for the specific purpose of:

* + Continuing care / Consultation
  + Sharing and exchange information with above mentioned persons for the purpose of providing assistance to my treatment.

I understand that my authorization will remain effective from the date of my signature until, \_\_\_\_/\_\_\_\_/\_\_\_\_\_, and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

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

Signature of Consumer/ Consumer’s Designated Representative Date

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

Witness Date