# Wellness Counseling Services

GENERAL AUTHORIZATION FORM

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NAME OF INDIVIDUAL: _____ DATE OF BIRTH: _____

I hereby authorize Wellness Counseling Services to use or disclose protected health information about me. The use or disclosure shall be limited to the information, persons, purposes, and time frame described below:

INFORMATION TO BE USED OR DISCLOSED
I authorize the use or disclosure of the following protected health information:
(describe the information as specifically as possible). **Write YES or NO on Each Line.**

_____ Official School Records (name, address, birth date, sex, attendance record, grade level, grades, class rank, standardizing group test results)
_____ Health Records
_____ Psychological Reports
_____ Special Education Records (including related services)
_____ Teacher, Counselor, Staff Observations
_____ Other (specify)
_____ Chemical Abuse/Dependency Report
_____ Medical Report (including related services)
_____ Social Work Report
_____ Other (specify) _____

PERSON TO USE OR RECEIVE THE INFORMATION
I authorize the following person(s) to use or receive the disclosure of my protected health information (Name/Title/Organization):

_____

_____

PURPOSE OF THE REQUESTSED USE OR DISCLOSURE
The protected health information may be used for each of the following purposes:
_____ At the request of the individual
_____ Coordination of county case management with counseling services
_____ Other (specify) _____

EXPIRATION DATE
This authorization will automatically expire :
_____ _____/_____/_____ (mm/dd/yy) (may not exceed 12 months from the date of the signature on this form); or
_____ When the following event occurs _____

PLEASE NOTE THE FOLLOWING
You may refuse to sign this authorization. Your refusal will <u>not</u> affect your ability to obtain treatment or payment. If the persons or entities authorized to receive the information are *not* health care providers or health plans covered by federal health privacy laws, they may redisclose the information and those laws would no longer protect the disclosed information. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can *revoke* this authorization by delivering a dated and signed letter to our clinic addressed to:

Wellness Counseling Services
7575 Golden Valley Road Suite 133
Golden Valley MN 55427

_____ When this is checked, our organization will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Individual's (or Legal Representative's) name (please print): _____

Individual's (or Legal Representative's) signature: _____ Date: _____

Capacity or authority of Legal Representative (if applicable): _____
(May be requested to provide verification of representative status)

Therapist's signature: _____ Date: _____