HIPAA Authorization and Consent for Release of Confidential Information

Creative Wellbeing Workshops, LLC

I, _____ (Client) hereby give my consent to _____ (CWW Provider) to:

- Release information to _____ (Name of Agency or Person).
- Consult with _____ (Name of Agency or Person) about my treatment.

Name/Address of person(s) or organization(s) from which information will be released.

_____

_____

Type of information

- ☐ Financial/Billing
- ☐ Current Location/Status
- ☐ Mental Health/ Psychological Evaluation
- ☐ Records of Treatment
- ☐ History/Physical

I have read the above, understand, agree, and hereby consent to the release of this information for the sole purpose(s) stated above. I understand that I may revoke my consent at any time by notifying the provider in writing. Revocation will be effective upon and after the date that the revocation is received by the provider. Any documents released previous to that date are considered to be authorized and approved by me.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____

Signature of Client Date

_____ _____

Printed Name of Client Date

_____ _____

Signature of CWW Provider Date

_____ _____

Printed Name of CWW Provider Date