# HIPAA Authorization and Consent for Release of Confidential Information to Primary Contact and/or Billing Contact

Creative Wellbeing Workshops, LLC

I, _____ (Client) hereby give my consent to **Rebecca Wilkinson** (Provider) to release the following information to _____ (Name of Primary Contact) at _____ (phone number) and/or _____ (email).

**Type of information:**

- ✓ **Financial/Billing**
- ✓ **Current Location/Status**

Mental Health/ Psychological Evaluation
Records of Treatment
History/Physical

I have read the above and understand that I may refuse to sign this consent without fear of repercussion. If I do agree and hereby voluntarily consent to the release of this information, it will be used for the sole purpose stated above.

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

_____ _____
Signature of CWW Provider Date

_____
Printed Name of CWW Provider