VANGUARD
MENTAL HEALTH & WELLNESS CLINIC, LLC

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AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize:
_____Vanguard Mental Health & Wellness Clinic, LLC _____
_____

To release to:
_____
_____

For the purpose of:

___ Continuation of care ____ Psychological Evaluation

The following information may be exchanged:

___ School records ___ Medical records ___ Clinic visits/Progress Notes

___ Psychological test results ___ Diagnosis ___ Other _____

I understand that the information being exchanged (and in my record) may include behavioral or mental health functioning, information regarding child abuse, and information regarding treatment for alcohol and drug abuse.

This authorization will expire in one year, unless it is revoked.

I understand that I have a right to stop this authorization at any time. If I stop this authorization, I must do so in writing to Vanguard Clinic. I understand that stopping this authorization will not apply to information that has already been released or disclosed for purposes of treatment, payment, and care operations.

I understand that signing the release of my records is voluntary. I can refuse to sign this authorization. It is not necessary for me to sign this from in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient Signature (or Parent/Guardian) Date
Relationship to patient: _____