Wholistic Therapeutic Services, LLC
P.O. Box 1743 Tifton, GA 31794
229-396-4689 and **229-396-4605** (Fax)
atanner.wts@outlook.com

AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

AUTHORIZATION-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to: **Alexia M. Tanner, LCSW/Jessie Van DeVelde, LAMFT, Joanna Byrd, MSW,** or **Provisional Intern with Wholistic Therapeutic Services, LLC.**

NAME/AGENCY________

Contact Information:_____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

___Summaries and notes of participation in treatment. ___ Evaluations and Recommendations

___Psychological and psychiatric testing & evaluation results ___ Treatment Plan, Progress & Discharge reports

___Information relating to medical history ___ Information relating to social history

Other information _____

PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

C. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW-

I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

___Substance abuse (drug or alcohol) information

___ Mental Health information

___AIDS-related information Client or (Guardian) Initials _____

D. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_12___months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to ____**Alexia M. Tanner, LCSW**_____.

E. I hereby authorize disclosure and/or receipt of protected health information as indicated on page 1 of this release and acknowledge that I may receive a copy of this document upon request.

F. This agency ☐ **Is Allowed** ☐ **Is NOT Allowed** to have contact and/or send documentation electronically, via non-encrypted email or other non-secured web-links.

_____

Client's Name (Print)

_____ _____

Client Signature Date of Signature

_____ _____

Witness Date of Signature

_____ _____ _____

(Print Minor Child's Name) **Minor Child's Date of Birth**

_____ _____

Parent/Legal Guardian Signature (if client is a minor) Date of Signature