Red Cliff
COUNSELING & WELLNESS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ Date of Birth: _____
(Client's Name and/ or Legal Guardian)
hereby authorize Red Cliff Counseling and Wellness to release information to and receive information from:

_____
(Person/Organization) (Telephone Number)

_____
(Address)

I understand that the purpose of this disclosure is to assist in the coordination of my care and that information to be disclosed includes:

- ☐ All mental health records
- ☐ Progress in treatment
- ☐ Diagnoses
- ☐ Treatment Plan
- ☐ Attendance
- ☐ Participation
- ☐ Evaluations
- ☐ Alcohol and/or drug addiction treatment
- ☐ Other_____

I certify that this request is made voluntarily. I understand that I may revoke, in writing, this authorization at any time, except on actions taken prior to its submission. I understand that once information has been disclosed, RCCW does not maintain control over privacy of protected information. This authorization will expire one year after the date it is signed. I agree that a photocopy or facsimile is as valid as an original.

_____ _____ _____

Signature of Patient/Client (or Legal Representative) Date Relationship to Patient

_____ _____

Witness Date