CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: Sabrina Santa Clara, PLLC DBA: Centers for Integrated Wellness
Sabrina Santa Clara, MA, LCPC, R-DMT, CIFST, RYT
2764 N Green Valley Parkwa7 #503, Henderson NV 89014
Cell 702.762.4100 Email: Info@SabrinaSantaClara.com Fax: 702.456.0492

☐ **To release information to** ☐ **To obtain information from**

(Check one box or both. By checking both, you are authorized an exchange of information between the agencies/individuals listed)

Agency/Individual ________________________________

Street: ________________________________

City/State/Zip: ________________________________

Individual: ________________________________

Phone: ________________________________

Fax: ________________________________

Email: ________________________________

From the records of:
Client Name: ________________________________

Date of Birth: ________________________________

Purpose or need for disclosure is to assist in the preparation of: (check all that apply)

☐ Coordination of Services ☐ Continued Treatment ☐ Legal ☐ Other (specify) ____________________

Type of information to be disclosed: (check all that apply)

☐ Complete Medical Records ☐ Medical ☐ Alcohol & Other Drug
☐ Mental Health ☐ Psychiatry Notes ☐ Psychothera;y Notes
☐ Legal Records ☐ HIV/AIDS ☐ Other (specify) ____________________

Specific information to be disclosed: ***(check all that apply)***

☐ Progress Reports ☐ Intake Summary ☐ Assessments + Diagnoses
☐ Case Notes ☐ MVD Status Reports ☐ Treatment Goals & Plans
☐ Clinical Impressions ☐ Personal Knowledge ☐ Other (specify) ____________________

I understand that:

a) My records are protected under State and Federal regulations governing confidentiality
b) My signature on this form is strictly voluntary
c) I may revoke this authorization at any time in writing, and if I do it will not have any affect on any actions taken prior to receiving the revocation. Further details ay be found in the Notice of Privacy Practices.
d) If the requestor or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
e) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.
f) I may inspect or obtain a copy of the health information that I am being asked to disclosed.

This consent (unless revoked earlier) expires 365 days from the signature date on: ____________________

________________________________ ____________________
Client Signature Date

________________________________ ____________________
Signature of Other Person Authorized to Consent (where applicable) Date

____
Relationship to Client

________________________________ ____________________
Witness Signature Date