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WAKE FOREST MIND AND HEALTH, PLLC
An Integrated Approach to Wellness
COUNSELING ~ COACHING
BIOFEEDBACK ~ STRESS MANAGEMENT

Authorization for Release of Information and Reciprocal Exchange of Information

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I hereby authorize Dr. Walker to share the specified information in my client record with the following individual or entity:

Name of Individual: ______________________________ Title / Credentials: ______________________________

Name of Practice, Agency, Facility, or Other Appropriate Entity: ______________________________

Street Address: ______________________________

City: ______________________________ State: _______ Zip Code: ____________________

Telephone Number: ______________________________ Fax Number: ______________________________

This data shall include (client or parent / legal guardian needs to initial next to each item to be released):

	Psychological Evaluation / Assessment		Biofeedback / Pain Management Treatment
	Biofeedback Evaluation / Assessment		Alcohol / Substance Abuse Treatment
	Treatment / Discharge Summary		Other:

The purpose of the disclosure is for:

- ☐ Assist with / coordination of treatment
- ☐ Referral
- ☐ At request of client
- ☐ Other ______________________________

Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this entity informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF AUTHORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

______________________________ ____________________
Client Signature Date

____
Client Name (Printed)

______________________________ ____________________
Parent / Legal Guardian Signature Date

____
Parent / Legal Guardian Name (Printed)