WELLSPRING PSYCHOTHERAPY

HIPAA Privacy Authorization Form / Release of Information

Authorization for Use or Disclosure of Protected Health and Mental Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Client Information:

Name_____
Date of Birth_____

Address_____
_____

Email_____
Phone_____

Preferred contact method_____

Emergency contact_____

Parent/Guardian Information:

Name/Names_____
_____

Address_____
_____

Email_____
Phone(s)_____

WELLSPRING PSYCHOTHERAPY LLC
Chris Peckham, LCPC NCC
7304 Carroll Ave, #207
Takoma Park, Maryland, 20192
202-246-3260

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Preferred contact method_____

I. Authorization

I_____ authorize Christopher Peckham LCPC, NCC to use, receive and disclose the protected health information described below for treatment purposes of _____. I consent to communication both verbal, written and electronic to and from the following parties.

1._____

2._____

3._____

4._____

II. Effective Period

This authorization for release of information covers the period of treatment and/or consultation for one year from the date which it is signed. This release/consent can be rescinded at any time by submitting a request in writing via email or letter. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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III. Extent of Authorization

I authorize the release of complete health records (including records relating to past mental health or behavioral health treatment / educational or psychological testing, communicable diseases, HIV or AIDS, COVID and or information specified below.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of client or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

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