



South Riding Wellness Connection

A balanced approach to mental, physical, and spiritual health

Authorization to Release Information

I, _____, authorize my therapist and/or the staff of the The South Riding Wellness Connection to **exchange** confidential health care information about me with:

Name

Agency/Address

Telephone/Fax

The information may be provided either orally, or in written form, and may include the following:

This disclosure is being made for the purpose of _____

As the person signing this authorization, I understand the following:

I am giving my permission to The South Riding Wellness Connection to disclose and/or receive confidential health care records.

I have the right to revoke this consent, except to the extent that it has been acted upon. My revocation is not effective until delivered in writing to Corpus Christi Family Services.

A copy of this consent, and a notation concerning the persons or agencies to whom disclosure was made, will be included with my original records.

I understand that neither my therapist nor The South Riding Wellness Connection can guarantee the continued confidentiality of any records released to the person or agency named in this authorization once they are out of the Center's possession.

I may receive a copy of my confidential health care information if I so request. If my information is shared in common with another person or persons, (for example the records of couple or family treatment), the other person(s) must consent to my receiving a copy of the information that we share in common.

I will be given a copy of this authorization.

This authorization expires on (date-not to exceed one year): _____

Signature of Client: _____

Date: _____