Release of Information

Patient Name

Date of Birth

I authorize Wilson Clinical Services, PLLC. to release my **protected health information (PHI)** to and / or obtain my PHI from the entity I have indicated below. This authorization is inclusive of all records / communications that may be useful in the continuity of my treatment, including:

- Psychological or neuropsychological exams;
- Charting notes
- Verbal Communication
- Medication information
- Psychotherapy notes
- Drug / alcohol abuse
- Lab tests / medical imaging
- Psychiatric evaluation

Third-Party Contact Name

Third-Party Contact Phone

Third-Party Contact Email

Third-Party Contact Fax

PHI from the following dates of service may be exchanged with the above entity (choose one):

☐ Any Dates of Service ☐ PHI Specifically Between the Following Dates:

Text

I authorize exchange of my PHI for the following reasons (choose one or both):

- ☐ Continuity of care (allows communication with other healthcare providers)
- ☐ At my request (allows communication with non-healthcare providers [e.g., employer or caregiver])

This authorization can be canceled at any time by request, in writing, but the cancellation will not affect any disclosures already made before receipt of the cancellation notice. This office cannot control how the protected health information will be used by the agency / person who receives it under this authorization.

Signature

Date