WILLOW TREE COUNSELING
102 W. Beaton Dr. Ste. 103, West Fargo, ND 58078
www.willowtreecounselingfm.com
Ph: 701.730.8313
Fax: 701.552.7975

Client_____Hereby authorizes Willow Tree Counseling PLLC to (*Check One*) **RELEASE** ☐ **RECEIVE** ☐ **EXCHANGE** ☐
with the party identified below:

CLIENT INFORMATION
Name:
Address:
City/State/Zip:
Home Phone Number:
Cell Phone Number:
DOB:
Fax:
Other:

AUTHORIZED TO RELEASE/RECEIVE/EXCHANGE INFORMATION
Name:
Organization:
Address:
City/State/Zip:
Home/Cell/Work Phone:
Home/Cell/Work Phone:
Email:
Fax:

Please specify the **dates of service** that information to be released/received/exchanged apply to: _____/_____/_____ to _____/_____/_____ OR ☐ All Dates of Service

This form **cannot be used for the re-release of confidential information** provided to Willow Tree Counseling PLLC by other individuals, providers, or agencies. Such requests should be referred to the original party which is pursuant with HIPAA. The above identified client authorizes Willow Tree Counseling PLLC to release the following information pertaining to client identified above:
Indicate all that apply. ✔ Indicates Permission to Release/Receive/Exchange Information by fax, encrypted email, verbally, or by paper document. If client chooses to have information released only verbally or written client must specify in writing as noted here:_____
Client Initials_____

History/Intake Information	☐	Attendance	☐	Billing	☐
Diagnostic Assessment/Summary	☐	Progress Notes	☐	Chemical Dependency Evaluation	☐
Psychological Test Results	☐	Discharge/Transfer Summary	☐		
Medical Information	☐	Discharge Plans	☐	Other:_____	☐
Medications	☐	Progress in Counseling	☐	_____	

The information will be used for (✔ all that apply):

Coordination with Other Professional	☐	Funding and/or Billing	☐	Care Coordination	☐
Collateral Information	☐	Legal Purposes	☐	Other:_____	☐
Coordinate Referral	☐	Emergency Contact	☐	_____	

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this authorization will expire as indicated on _____. If no date is entered this authorization will **expire one year from the date of signing this form**.
The above identified client authorizes Willow Tree Counseling PLLC to **release mental health and/or substance abuse treatment records** in compliance with Health Information Portability and Accountability Act (HIPAA) and with federal and state laws. By signing this release the client hereby authorize the release of my patient information stated above and release Willow Tree Counseling, PLLC from any legal responsibility or liability relating to the release of information. **This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a client has having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual who information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any client with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65. If the identified client has authorized the disclosure of Protected Health Information to someone who is not legally required to keep it confidential it may no longer be protected by state and/or federal law.**
CLIENT RIGHTS: This authorization to release Protected Health Information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: 1) To conduct research-related treatment, 2) To obtain information in connection with eligibility or enrollment in a health plan, 3) To determine an entity's obligation to pay a claim or 4) To create health information to provide to a third party. **This authorization may be revoked at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.** The revocation must be in writing, signed by the client or the client's representative, and delivered to: Willow Tree Counseling PLLC, 102 W. Beaton Dr., Ste. 103, West Fargo, ND 58078. The revocation will take effect once Willow Tree Counseling receives it and any information released prior to the client providing written revocation of this release shall not be a breach of confidentiality. **Client has the right to review and/or receive a copy of the information to be disclosed if the client signs a separate authorization to his/her self to receive a copy. Client understands that WTC is no longer responsible for who and how the client elects to share released medical records with.**
You are entitled to receive a **copy** of this Authorization. **Please circle one**: ☐ Client Accepted Copy OR ☐ Client Declined Copy

Client Signature	Date	Client Representative Signature	Date
Provider Signature (If present when signed)	Date	Witness Signature	Date

06/2023

*A copy of this authorization is as valid as the original