



WOTC Authorization for the Release of Personal Health Information

Client Information

Date: ____ / ____ / ____

Name _____

Phone Number: _____ DOB: ____ / ____ / ____

Client Address: _____ City: _____ State: _____
Zip Code: _____

Client Email: _____

Willow Oak Therapist Name: _____

I, [Client Name] _____ give my permission for Willow Oak Therapy Center, Inc., including its employees and agents, as well as my therapist(s), to disclose to and receive from the following individual or organization information pertaining to my health (my “protected health information” or “PHI”), including information related to my current and previous psychotherapy or hospitalization, and any of my medical records given to Willow Oak Therapy Center or my therapist(s) by another health care provider who has not prohibited re-disclosure of the record:

Provider Name: _____

Provider Address: _____

Provider Phone Number: _____ - _____ - _____

Provider Fax Number: _____

Provider Email: _____



I permit the above-referenced disclosures for the following purposes:
[Statement of specific purpose(s), e.g., “any purpose relating to my health, the payment for my health care, the study of mental health, research on the relationship between mental and physical health,” etc.] **for assessment and treatment planning.**

I understand that once my PHI is shared based on this authorization, federal privacy law may not prevent the persons or entities receiving the information from further disclosing it to others. I also understand that I have the right to revoke this authorization at any time by sending a written notice of my revocation to Willow Oak Therapy Center at the address at the top of this page. Such revocation will prohibit reliance on this authorization after the date upon which Willow Oak Therapy Center receives the notice, but I understand that the use and re-disclosure of PHI already disclosed prior to that date will not be subject to the revocation.

I understand that Willow Oak Therapy Center may not condition my medical treatment or eligibility for medical benefits on my agreement to sign this authorization.

This authorization will remain in effect until _____ or one year after the date of my signature below, whichever is sooner.

Sign Here: _____ **Date:** ___ / ___ / ___

Time: _____ ET

****By signing this I acknowledge that I've read, fully understand and agree to all information contained here****