

**Release of Information &/or Authorization to Acquire Information**

I, (please print name in space provided) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the specific agencies/individuals listed on this form to release to MBH Wellness Clinic, and relevant employees of MBH Wellness Clinic, all information necessary to carry out the assessment of, treatment plan for, and therapeutic care of this client.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person or Agency Phone Number

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Name of Person or Agency Phone Number

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Name of Person or Agency Phone Number

**Per policy of this clinic, *all clients* treated at MBH Wellness Clinic need *at least one* designated person an employee could contact on client’s behalf in case of emergency throughout the duration of care provided to you. This emergency contact can be changed by you at any time.**

In Case of Emergency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Number

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Name Phone Number

The consent to share information with or provide information to the above person(s) or agency may be revoked at any time. By ending the consent, no further information will be shared. I understand that the duration of this consent will not be longer than necessary and reasonable to carry out the purpose for which consent was given.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Primary Caregiver Date

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Witness Signature Date

*This form meets the requirements of Federal Regulation 42CFR Part II.*