RELEASE OF INFORMATION

Achieve Wellness Group, LLC
13039 W. Linebaugh Ave., Bldg. V, Suite 101, Tampa, FL 33626
Phone: 888-531-1313 Fax: 888-551-6035

AUTHORIZATION TO RECORDS CUSTODIAN FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION INCLUDING PSYCHOLOGICAL INFORMATION IN PSYCHOTHERAPY, EVALUATION, SESSION NOTES AND TESTING RESULTS

Patient Name: _____ DOB: _____ SS#: _____
By signing this form, understand that I or my legal representative am authorizing the designated medical records custodians or database custodians at the office of Achieve Wellness Group, LLC (AWG) to use and/or disclose my protected health information (PHI) as defined under 45 CFR 160-164, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization:

_____ (initial here) RELEASE TO and/or _____ (initial here) RECEIVE FROM:

Name/Organization: _____

Street Address:_____

City, State, Zip Code: _____

Telephone Number: _____ Fax: _____

I specifically authorize the use and disclosure of the following PHI:

Information to be RELEASED BY AWG:	**Information to be RECEIVED BY AWG:**
_____ALL records in your custody	**_____ALL records in your custody**
_____ONLY the following:	**_____ONLY the following:**
_____Records of treating provider/physician/clinician	**_____Records of treating Psychologist**
_____Initial evaluation/Diagnostic interview	**_____Initial evaluation/Diagnostic interview**
_____Follow-up/progress notes	**_____Follow-up/progress notes**
_____Psychological test results/assessment report	**_____Psychological test results/assessment report**
_____Medication notes	**_____Medication notes**
_____Verbal reports	**_____Verbal reports**
_____Billing records	**_____Billing records**
_____Consultation Reports	**_____Consultation Reports**
_____Other:_____	**_____Other:_____**

The information to be used or disclosed pursuant to this authorization form may include information relating to psychological care, including psychotherapy session notes as defined in 45 CFR 164 501. If I am the patient requesting my own psychological treatment records, I understand that I may review a summary report of evaluation and treatment instead of copies of psychological records. I may revoke this authorization at any time by notifying the above-referenced records custodian of my intent to revoke authorization (returning this form with signature and date and the words "authorization revoked" is sufficient notice). However, I understand that such revocation will not have any effect on any information that may have already been used or disclosed prior to my written notice of revocation. This authorization will expire one (1) year after the date of signing. I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form. I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from Achieve Wellness Group, LLC. I also understand that payment, enrollment in a health plan, and/or eligibility for benefits will not be conditioned upon signing this form. I understand that I may refuse to sign this form.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Printed Name of Patient or Legal Representative **Relationship to Patient**