Wellspring Counseling, LLC
Healing Anxiety, Depression & OCD
Nina Rifkind, LCSW, ACS, Owner

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Client's name), whose date of birth is: _____

authorize Nina Rifkind, LCSW of Nina F. Rifkind, LCSW, LLC to disclose to and/or obtain from

_____the following information related to my treatment:

_____ Assessment	_____ Treatment Plan or Summary	_____ General Medical Information
_____ Diagnosis	_____ Current Treatment Update	_____ Educational Information
_____ Progress in Treatment	_____ Continuing Care Plan	_____ Demographic Information
_____ Participation in Treatment	_____ Medication Mgmt. Information	_____ Discharge/Transfer Summary

_____ Other: _____

Purpose: The purpose of this disclosure and/or exchange of information is to improve assessment and treatment planning, share information relevant to treatment, coordinate treatment services and ensure the overall continuity of care.

Revocation: I understand that I may revoke this authorization at any time by notifying Nina Rifkind, LCSW at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.

Re-disclosure: I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.

Refusal to Sign: I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.

Form of Disclosure*:* Unless specifically requested in writing that disclosure be made in a certain format, Nina F. Rifkind, LCSW reserves the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

____ Check here if client/parent or legal guardian refuses to sign authorization

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Legal Guardian/Authorized Person Date

Nina F. Rifkind, LCSW

_____ _____

Clinician Signature Date