

Katherine E. Walker, PhD, LPC, NCC, BCIA-C

Licensed Professional Counselor

501 North Main Street
Wake Forest, NC 27587

Cell: 919-760-3068

Fax: 919-263-2488

Email: katie@wakeforestmindandhealth.com



Authorization for Release of Information and Reciprocal Exchange of Information

I hereby authorize Dr. Walker to share the specified information in my client record with the following individual or entity:

Name of Individual: _____ Title / Credentials: _____

Name of Practice, Agency, Facility, or Other Appropriate Entity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

This data shall include (client or parent / legal guardian needs to initial next to each item to be released):

<input type="checkbox"/>	Psychological Evaluation / Assessment	<input type="checkbox"/>	Biofeedback / Pain Management Treatment
<input type="checkbox"/>	Biofeedback Evaluation / Assessment	<input type="checkbox"/>	Alcohol / Substance Abuse Treatment
<input type="checkbox"/>	Treatment / Discharge Summary	<input type="checkbox"/>	Other: _____

The purpose of the disclosure is for:

- Assist with / coordination of treatment
- Referral
- At request of client
- Other _____

Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this entity informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF AUTHORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

Client Signature

Date

Client Name (Printed)

Parent / Legal Guardian Signature

Date

Parent / Legal Guardian Name (Printed)