The Wellness Center RI, LLC
400 Reservoir Ave.
Providence, RI 02907
Phone: (401) 461-9355 Fax: (401) 784-9609

Authorization for Release of Information

_____ _____
Client's Name: Date of Birth

Authorizes The Wellness Center RI, LLC to OBTAIN from and RELEASE to:

Name: _____

Address: _____

The information to be released pertaining to my identity, prognosis, diagnosis or treatment shall include:
❍ Progress Notes ❍Treatment summary ❍ Psychiatric evaluation
❍ Discharge summary ❍ Psychosocial history ❍ Psychological testing/report
❍ other (specify)_____

This information is needed for the following purpose(s):

❍ Evaluation & Treatment ❍ Other_____

Permission for exchange of information will continue for the duration of the client's treatment or date otherwise specified. Permission may be withdrawn at any time through a signed written statement. **Expires:_____**

I understand that records of The Wellness Center RI, are protected under Rhode Island General Law and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that if my records involve alcohol or drug abuse they are protected under the Federal Regulation 42 CFR, confidentiality of Alcohol and Drug Abuse.

I release the The Wellness Center RI, and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information to those person/agencies named above.

I also consent to the release of my records or any part thereof, through the use of a facsimile machine, with the understanding The Wellness Center RI, cannot exclusively guarantee the confidential transmittal of records via Fax delivery. ❍ Yes ❍No

_____ _____
Signature of Client or legal guardian: Date:

_____ _____
Witness from The Wellness Center RI Date: