

BOX 1 Identify the client whose records are to be released.

Full Name _____ DOB _____ SS# (optional) _____
 Address _____ Phone (____) _____
 City _____ State _____ Zip _____

BOX 2 Please read the choices below and write in "Option 1" or a description in the right-hand column below.

Option 1: Any and all records held by WellHome Psychology, PC including history, evaluation, testing, treatment and recommendations, **which includes medical and mental health records, Substance Abuse records and Communicable Disease records**, including but not limited to mention of Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and Hepatitis.

Option 2: If you wish to strictly limit access to your records, identify information that may be released

BOX 3 WellHome Psychology, PC may release the information identified below to the following agencies or individuals. Check each agency/ person that may receive information from WellHome Psychology, PC.

√	Name of person or agency and location of agency AND phone number. (REQUIRED)	Write in Option 1 or write in a description of the information to be released. (REQUIRED)
	Family/Significant Other	
	Family/Significant Other	
	Other provider	
	Doctor	
	School	
	Employer	
	Voc Rehab	
	Social Security Admin	
	Landlord/ HUD	
	Court/Probation//Parole	
	Jail/ Juvenile facility	
	FSSA	
	Hospital	
	Referral Source	
	Transportation provider	
	Bank/ financial institution	
	Attorney	

BOX 4 Right to revoke: I understand that I can change my mind and revoke this authorization at any time in writing, except to the extent that a release of information has already been made under this authorization. (Authorization to release substance abuse program information may be revoked orally.)

State when you want this authorization to expire:
 This authorization expires on this Date: _____
 (If no date is entered this authorization will expire 180 days from date of signature.)

I grant my authorization to WellHome Psychology, PC and its employees to release my protected health information under the terms described in this document. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. If I have any questions, I can contact WellHome Psychology, PC at 219-802-6464. I agree that information may be transmitted by US mail, fax, email or phone as required by referral or payor sources and to meet timeliness guidelines.

Signature of Client or authorized representative * _____ Print name _____

*If this authorization is for Substance Abuse records of a minor, only the minor can sign the authorization.

Date Signed _____

Please check one:

I am the client whose records are to be released.

I am the parent, legal guardian, personal representative, health care POA, or other court-appointed representative of this client

Indicate which of the above applies: _____

Please provide a copy of legal appointment papers

This authorization REVOKED on _____ Received by _____) How: Written? Oral?

WellHome PSY use only: Form validated by: _____	Client _____ ID # _____
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