|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Authorization to Release or Obtain Protected Health Information**  ***PLEASE PRINT*** | | | | | | MRN# | |
| Patient Name: (Last) |  | (First) | |  |  | |  |
| Phone: |  | Maiden/Other Name: | |  |  | |  |
| Date of Birth: |  | Social Sec. No. | |  |  | |  |
| Address: | | | | | | | |
| City: |  | State: | |  | Zip: | |  |
| **I authorize Well Being Health Care, LLC to release information contained in my medical/clinical record to the following person or organization indicated below:** | | | **INFORMATION TO BE RELEASED**  Check or Circle  Please indicate date(s) or date range, if known | | | | |
| Institution or Requestor: | | | Intake Notes | | | | |
| Attention to: | | | E&M / Office Notes | | | | |
| Address: | | | X-Ray Report | | | | |
| City | State | Zip | Blood Test Results | | | | |
| Phone | | | Other Lab Results | | | | |
| **I authorize the following institution to release protected health information contained in my medical record to Well Being Health Care, LLC:** | | | Treatment Info | | | | |
| Counseling Notes | | | | |
| Discharge Summary | | | | |
| Institution or Requestor: | | | Other: | | | | |
| Phone: | | | Comments: | | | | |
|  | | |  | | | | |
| **REASON FOR DISCLOSURE**  Check or Circle | | | **Please Check if you want Information Protected by CFR 42 Released:** | | | | |
| Continuation of Care  Medical Consultation | | | Drug Abuse  Psychotherapy Notes | | | | |
| Legal Representative | | | Alcohol Abuse  STD Test Results | | | | |
| Social Security Disability  Claim# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | HIV/AIDS | | | | |
| Worker's Comp  Insurance Claim#\_\_\_\_\_\_\_\_\_\_ | | | Anticipated Completion Date: (Please Circle One)  30 Days | | | | |
| Other: | | | 60 Days | | | | |
|  | | | 90 Days | | | | |
| **This authorization to disclose information may be revoked by the patient at any time except to the extent that action has been taken in reliance thereon by sending a written revocation to the Compliance Officer Well Being Health Care, LLC 11 Arley Way Suite#202 Bluffton, SC 29910 This authorization expires 60 days from the date of signature.** | | | | | | | |
| Signature of Patient |  |  | | Date: |  | |  |
| Other Legal Signature |  |  | | Date: |  | |  |
| **FOR**  **Well Being Health Care, LLC USE ONLY BELOW** | | | | | | | |
| Approved  Denied |  | Completion Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  | | IDENTIFICATION VERIFIED  Driver’s License  Other Photo ID  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee Signature |
|  |  |  | |  |  | |  |
|  |  |  | |  |  | |  |