|  |  |
| --- | --- |
| **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 CirclePlease 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 VERIFIEDDriver’s License Other Photo ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Signature  |
|   |  |  |  |  |  |
|    |  |   |  |    |    |