Authorization to Release Protected Health Information **FORM B (Multiple authorizations)** **2021**

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. C**heck each agency/ person that may receive information from WellHome Psychology, PC.**

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

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 219-202-6365. 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** Date Signed

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

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?**

Rev. 04-01-21 Form B Multiple

WellHome PSY use only:
Form validated by: _____

Client _____
ID # _____