CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

INSTRUCTIONS: Please print. Fill in **ALL** blanks on this form.

Name: ______________________________________ Birthdate: ______________ Phone: ___________________
Last First M MM/DD/YYYY Area code Number

Address: ____
Street City State Zip

I hereby authorize the release of confidential information to Midwest Wellness Institute:

Facility name: ____

Address: ____
Street City State Zip

Phone: ____ Fax: ____
Area code Number Area code Number

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The following information:

- ☐ Mental Health Diagnostic Assessment
- ☐ Mental Health Progress Notes
- ☐ Discharge Summary
- ☐ Psychological Evaluation & Notes
- ☐ Psychiatric Evaluation & Notes
- ☐ Medical Records from__________ to __current___
- ☐ Evaluation/Testing Results
- ☐ Medication lists/lab results

THE PURPOSE FOR DISCLOSURE IS

- ☐ Continuing care/treatment planning
- ☐ Other (specify) ____________________________

I understand that I have the right to refuse to sign this consent. I understand that under most circumstances a healthcare provider may not deny treatment if this consent is not signed. I may inspect or request copies of any information disclosed under this consent and will receive a copy of this consent once signed. I understand that I may revoke this consent at any time by written notice to the Medical Records staff or Compliance Office and that revocation will not have any effect on the information release prior to revocation. I understand that this consent expires on year after signature date.

____ ____
Signature Signature of parent/guardian Relationship

____
Date (MM/DD/YYYY)

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