WELLNESS
PSYCHOLOGICAL SERVICES

Release of Protected Health Information Consent

I _____, authorize Wellness Psychological Services, PLLC, including its employees, to exchange general medical and psychiatric/psychological information as defined in the document below:

INFORMATION TO BE TRANSMITTED IS AS FOLLOWS:

[ ] Admission/Discharge Summary
[ ] Academic Records
[ ] Lab & Other Diagnostic Data
[ ] Medical History
[ ] Medication Summary
[ ] Psychological Evaluation
[ ] Psychological Test/Raw Data
[ ] Progress Notes
[ ] Treatment Plan & Updates
[ ] Other: _____

PURPOSE OF RELEASE:

[ ] Treatment Planning/Consultation
[ ] Release of Evaluation
[ ] Verification of Treatment/Attendance
[ ] Legal
[ ] Reimbursement
[ ] Other: _____

_____ FROM: _____ BETWEEN: _____ TO:

_____ _____
_____ _____
_____ _____

This authorization expire on: _____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand I have a right to receive a copy of this authorization. I further understand that the information disclosed to the recipient may not be protected if the recipient is not a health care provider covered by the state or federal rules.

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative (if applicable) Date

Relationship of Personal Representative to Patient: _____