WellServe Health
AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION
6200 Aurora Ave. Suite 307E, Urbandale, IA 50322 | Phone: 515-461-9316 Fax: 515-461-9051

Please complete this form in its entirety. Items not checked or initialed or left blank are assumed to be non-applicable or specifically not authorized for release. This release is invalid if it does not contain the individual's signature or mark and date signed or if it has expired as described below.

INDIVIDUAL'S INFORMATION:		
First Name:	Last Name:	DOB:
Address:		

PARTY RELEASING THE INFORMATION [PARTY 1]:	**INFORMATION RECEIVING PARTY [PARTY 2]:**
Name: WellServe Health, Inc.	Name:
Address: 6200 Aurora Ave. Suite 307E, Urbandale, IA 50322	Address:

RECIPROCAL COMMUNICATION AUTHORIZATION:

I authorize the exchange of information between [Party 1] and [Party 2], including both the release and receipt of information, for the purpose of coordinating care:
☐ Yes ☐ No

THE INFORMATION BEING RELEASED/OBTAINED WILL BE USED FOR THE FOLLOWING PURPOSE(S):

☐ Yes ☐ No: Planning and implementation
☐ Yes ☐ No: Coordination of services
☐ Yes ☐ No: Individual's request
☐ Yes ☐ No: Referral for new services
☐ Yes ☐ No: Other (Specify): _____

INFORMATION TO BE RELEASED/OBTAINED:

☐ Yes ☐ No: Service Plans
☐ Yes ☐ No: Progress Notes
☐ Yes ☐ No: Discharge Summary
☐ Yes ☐ No: Medical History
☐ Yes ☐ No: Personal Finances
☐ Yes ☐ No: Evaluations/ Assessments / Social Histories
☐ Yes ☐ No: Criminal History
☐ Yes ☐ No: Other (Specify) _____

METHOD OF RELEASE:

☐ Yes ☐ No: Verbal (phone or in person)
☐ Yes ☐ No: Written (deliver or in person)
☐ Yes ☐ No: Electronic (email/fax etc.)
☐ Yes ☐ No: Other: _____

SPECIFIC AUTHORIZATION FOR RELEASE	**TYPE OF INFORMATION**	**AUTHORIZING INITIALS**
I authorize the release of the information listed at the right, which requires specific consent under law:	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

I give WellServe Health, Inc. or the named agency my permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purpose I have checked. I understand that all of the information marked above may contain Protected Health Information (PHI) and authorize this disclosure by the methods I have chosen. I understand that this release is valid up to the expiration date stated below, and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment, support, payment, or my eligibility for benefits. Any revocation will take effect on the day it is received in writing by WellServe Health, Inc. at 6200 Aurora Ave Suite 307E, Urbandale, IA 50322. I understand I have the right to access my records which may be obtained with reasonable notice and payment for printing costs. I further understand that if the person or entity that receives the above specified information is not a covered HIPAA entity or a business associate of a covered HIPAA entity, the information described above may be redisclosed and no longer protected by the regulations.

AUTHORIZING SIGNATURE:	**DATE:**
This authorization shall expire on (not to exceed 365 days from the date signed):	
Relationship to Individual: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other - Specify:	
Witness signature:	
Witness signature:	

UPDATED 1/2/2025 * Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information. ** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.