WellServe Health, Inc
AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION
6200 Aurora Ave. Suite 307E Urbandale, IA 50322
Phone: 1-515-461-9316 Fax: 1-515-461-9051

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 patient's signature or mark and date signed or if it has expired as described below.

CONSUMER: _____ DOB _____ SS # _____

Agency Releasing the Information:

Name: **WellServe Health, Inc**
Address: 108 3rd St #312
Des Moines, IA 50309

Information receiving party:

Name: _____
Address: _____
_____

Check here if both parties will be receiving and releasing information: □ Yes □ No

The information being released will be used for the following purpose:

[ ] Yes [ ]No: Planning and implementation of my Individual Program Plan
[ ]Yes [ ] No: Coordination of services
[ ]Yes [ ]No: Monitoring of services
[ ]Yes [ ] No: Referral for new services
[ ] Yes [ ] No: Other (Specify): _____

INFORMATION TO BE RELEASED/OBTAINED:

[ ] Yes [ ] No: SOCIAL HISTORY
[ ] Yes [ ] No: EDUCATIONAL/VOCATIONAL PLANS
[ ]Yes [ ]No: ANNUAL STAFFING REPORTS
[ ] Yes [ ]No: DISCHARGE SUMMARY
[ ] Yes [ ]No: MEDICAL HISTORY
[ ]Yes [ ] No: PERSONAL FINANCES AND BUSINESS
[ ] Yes [ ]No: PROGRESS SUMMARY REPORT
[ ] Yes [ ] No: INDIVIDUAL PROGRAM/SERVICE PLAN
[ ] Yes [ ] No: PSYCHOLOGICAL EVALUATIONS
[ ] Yes [ ] No: PSYCHIATRIC ASSESSMENT/REPORT
[ ] Yes [ ] No: TREATMENT PLAN
[ ]Yes [ ] No: OTHER (Specify) _____

Method of Release: [ ]Yes [ ] No: Verbal (phone or in person)
[ ] Yes [ ] No: Written (post office or carrier delivery)
[ ]Yes [ ] No: Facsimile (electronic over phone lines)
[ ] Yes [ ] No: Email
[ ] Yes [ ] No: Other (specify) _____

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 these reports, notes, plans and other Information marked above may contain Personally Identifying Information and authorize this disclosure by the methods I have chosen. I understand that this release is valid up to the expiration date stated above, 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. WellServe may notify the information receiving party that the release has been revoked. As a consumer I have the right to access my records. Copies of the records may be obtained with reasonable notice and payment for copying cost. 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.

This authorization shall expire on:_____ (not to exceed 365 days from the date signed)

Signature of **Consumer** (or **Guardian if applicable**): _____ **Date**: _____
[Circle appropriate word]

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE/FEDERAL LAW
I specifically authorize the release of data and information relating to:

[ ] Yes [ ]No: Substance Abuse (Alcohol/Drug Use)
[ ]Yes [ ] No: Mental Health (Including psychological testing)
[ ] Yes [ ]No: HIV-Related Information (Aids Related Testing)

Signature of **Consumer**: _____ **Date**: _____
(Required if "any of the above are checked" is checked "Yes")
Signature of **Guardian if applicable**: _____ **Date**: _____

Request for copy of Release: Guardian? Yes____ No____ Consumer? Yes____ No___

Witnessed By: _____ Date: _____
(Must be witnessed if signed by a mark instead of a signature)