WELCOME HOME MINISTRIES

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____ S.S. #: _____-____-_____ DOB: _____

ADDRESS: _____

I hereby authorize the release of the following specific information from/to:
(check only items that apply)

yes no (1) Medical history, examination, laboratory tests and treatment reports.
yes no (2) Psychological test reports.
yes no (3) Psychiatric evaluation reports.
yes no (4) Social history data including family, education, employment and other related material
yes no (5) Summary of previous mental health treatment.
yes no (6) Periodic reports of current treatment progress including attendance and participation.
yes no (7) Notification to referral source of initiation and termination.
yes no (8) Specify: _____

Release from – to: _____
(name of agency or individual)

Address: _____

I understand that this information will be used for the following specific purposes:
(check all items that apply)

yes no (1) To develop a diagnosis, treatment and plan.
yes no (2) To coordinate medical, psychological and social rehabilitation processes.
yes no (3) To coordinate services.
yes no (4) Specify: _____

I understand no information may be re-disclosed by either agency to any other individual or agency unless by written consent. This authorization may be revoked at any time by my written statement. This consent for release of information is given freely, voluntarily and without coercion.

_____ Date: _____
(Signature)

_____ Date: _____
(Signature)