WRCMW Release of Information Consent

Western Reserve Center For Mental Wellness
29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122
(216) 230-8100 (216) 230-8215 fax
hello@wrcmw.com

** indicates a required field*

Patient information:

Patient name:

Patient date of birth

Patient address:

Patient (or parent/guardian) phone number:

Patient (or parent/guardian) email:

* I authorize Noah Miller MD and Western Reserve Center For Mental Wellness LLC to:

- [ ] Send
- [ ] Receive

* The following information:

- [ ] Medical history and evaluation(s)
- [ ] Mental health history and evaluation(s)
- [ ] Developmental and/or social history
- [ ] Educational records
- [ ] Progress notes, and treatment or closing summary
- [ ] *Alcohol/drug dependence/abuse history
- [ ] *Therapy notes
- [ ] Entire record (excluding * items)
- [ ] Other

To / From:

Name:

Address:

Phone:

Fax:

Email:

* Your relationship to client:

- ○ Self
- ○ Parent/legal guardian
- ○ Legal representative
- ○ Other

* The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or programming
- ☐ Continuing appropriate treatment and coordination of care
- ☐ Determining eligibility for benefits or program
- ☐ Updating files
- ☐ Scheduling and confirming appointments
- ☐ Paying for services and account inquiries
- ☐ Other
- ☐ This disclosure is at the patient's (or parent's/guardian's) request

I, the undersigned, authorize Noah Miller MD and Western Reserve Center For Mental Wellness LLC to release/receive information to/from my medical records as described above. I understand and acknowledge that the medical record may contain

information regarding psychiatric disorders, alcohol and/or drug dependence/abuse, HIV test results, and/or AIDS-related conditions.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization.

I understand that I have a right to refuse to sign this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand that there may be charges for the copying and release of this information and accept financial responsibility.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* **Signature:** _____

I consent to sharing information provided here.

*** Date:**

Witness signature (if client is unable to sign):

Witness Date: