Request for Release of Information

* indicates a required field

The release of information only needs to be completed if you would like Christy Hey/Quo Vadis Wellness LLC to connect with another provider. This form may also be utilized to request a release of your health records for personal, medical, or legal reasons. In addition, if you are asking another individual to make appointments or take care of billing on your behalf, please fill out this form for that purpose (includes minors 14 and up).

* Client name:

* Date of Birth (mm/dd/yyyy):

* I request and authorize Quo Vadis Wellness LLC and Christy Hey to:

- ▢ Send
- ▢ Receive

* To / From (agency or person requested):

* Phone/email/fax/address:

* The following information:

- ▢ Medical history and evaluation(s)
- ▢ Mental health evaluations
- ▢ Developmental and/or social history
- ▢ Educational records
- ▢ Progress notes, and treatment or closing summary
- ▢ Billing information
- ▢ Scheduling information
- ▢ Other:

* Your relationship to client:

- ◯ Self
- ◯ Parent/legal guardian
- ◯ Personal representative
- ◯ Other:

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

- ▢ Planning appropriate treatment or program
- ▢ Continuing appropriate treatment or program
- ▢ Determining eligibility for benefits or program
- ▢ Case review
- ▢ Updating files
- ▢ Other (please specify): _____

1. 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

2. 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.

3. I consent to sharing the information provided here.

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.

* Date (mm/dd/yyyy):

* Signature of client (or guardian if client is under 14):