Authorization to Disclose Protected Health Information

Printed Name: ______________________ SSN: (last 4 digits): ____________ DOB: _______________

I hereby Authorize: Name of Doctor or Clinic: _________________________________
Address: ________________________________
City: _________________State: _____ Zip: ____
Phone: _______________ Fax: ______________

☒ Release to: Name/ Facility: ___Work Services Corporation (WSC)_
Address: _____1343 Hatton Rd__________________
City: __Wichita Falls____ State: _TX___ Zip: _76302_
Phone: _(940) 766-3207__Fax: _(940) 766-6448____

Information to be Released: (Check all that apply)

Dates of Services Requested: From: ________ To: _________

Mental Health

☐ All Records
☐ Behavior Support Plan
☐ Psychiatric/Psychological Evaluation
☐ Intervention Progress Notes
☐ School/ISD (CW/ Diagnosis and Evaluator Name or Elect. Signature)
☐ Psychological Evaluation/ DID
☐ Labs/ Physician Orders
☐ Assessments
☐ Full individual Evaluation
☐ Progress Notes (CW/ Physician)
☐ Nursing Observation Notes
☐ ICAP/Testing/Summary
☐ Verbal Exchange
☐ Other: _____________

School Records

☐ REED/Evaluation
☐ IEP
☐ Diagnostic Report/Evaluation

Medical Records

☐ All Health Information
☐ Physician Orders
☐ Progress Notes
☐ History/Physical Exam
☐ Patient Allergies
☐ Discharge Summary
☐ Diagnostic Test Reports
☐ Other__________

Reasons for Disclosure

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Financial assistance
☐ Other__________

***Initials required to release the following information**

______Drug, Alcohol, Substance abuse records
______HIV/AIDS test results/treatment

___________________________ ______________________
Applicant/ Employee Signature Date

___________________________ ______________________
WSC Staff Date