This authorization is voluntary. I understand that Wentworth and Associates will not base treatment, payment, enrollment or eligibility for benefits based on my signing this document.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden/AKA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zipcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I request that Wentworth and Associates release my protected health information to **Myself** to the address noted above.

Please select a delivery method: 🞎 US Mail 🞎 Pick up from Wentworth and Associates

* Other: I am a legally authorized representative requesting the information of the patient listed above.

Relationship to the patient listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select a delivery method: 🞎 US Mail 🞎 Pick up from Wentworth and Associates

🞎 I am requesting my records be sent from :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to Wentworth and Associates

Information Requested: Please Check all that apply

* All Medical Records 🞎 Billing Information
* Dates of service from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Psychological Evaluation 🞎 Psychiatric Evaluation
* Notes

I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal Privacy regulations. Wentworth and Associates, P.C. as well as former associates, are released from all legal liabilities for the release of the above requested information.

I understand that requests for records can take up to three business days to gain approval from my treating clinician, and up to five business days to be dispersed to the requesting party( not including time needed for any mailed documents, holidays or weekends). I also understand that reviewing of treatment records may, in some situations be more harmful than beneficial as treatment records serve the purpose of documenting true client state at time of service.

Medical Records are subjected to a $25.00 charge per request.

This authorization expires on : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the expiration date is left blank the authorization expires 60 days from the signature date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or legal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian Date