Unchained Wellness Center

Direct: (480) 536-9473
Fax: (480) 536-9744

CLIENT CONSENT TO RELEASE INFORMATION

Client Name:_____ Date of Birth: _____

Other Alias:_____ SSN:_____/_____/_____

I hereby authorize **the below health care or pharmacy providers** to use or disclose, in verbal and/or written form, the specific information requested below, to Unchained Wellness Center for the purpose of receiving TMS therapy and to obtain prior-authorization for TMS treatment services.

(Doctor Name)_____ Tele:_____ Fax:_____
(Doctor Name)_____ Tele:_____ Fax:_____
(Pharmacy)_____ Tele:_____ Fax:_____
(Pharmacy)_____ Tele:_____ Fax:_____
(Hospital)_____ Tele:_____ Fax:_____
(Therapist)_____ Tele:_____ Fax:_____
(Other)_____ Tele:_____ Fax:_____

One-Way Release: _____ Two-Way Release: _____

We have checked the minimum records needed to obtain a prior authorization for TMS therapy. Please check any other applicable mental health records you authorize us to request.

__X__ Treatment Summary
_____ Psychological Testing
_____ Psychological Evaluation
__X__ Psychiatric History
_____ Substance Use/Abuse History
_____ School Functioning/Educational
_____ School Testing/Evaluations
_____ Medical Information History
__X__ Current / Previous Medications
_____ Hospital Admit Summary
_____ Hospital Discharge Summary
_____ Other: _____

The information is being requested for the following purpose(s):
Transcranial Magnetic Stimulation (TMS therapy)

This authorization shall remain in effect for 90-days from the date of the request.

Continued on the reverse →

Unchained Wellness Center

Date of Request: _____

This authorization shall remain in effect 90-days from the date signed below.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to Unchained Wellness Center
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization
- I hereby release Unchained Wellness Center from any and all legal responsibility or liability or for any consequences of either: 1) having non- stipulated information maintained
  in confidence or privacy; or 2) disclosing stipulated information.

Client Signature: _____ Date: _____
(Age 18 and over)

Parent/Guardian Signature: _____ Date: _____

Witness Name: _____ Date: _____
The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.

Unchained Wellness Center
201 W Guadalupe Rd., Ste. 302
Gilbert, AZ 85233
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