

The Wright House Wellness Center  
Request for Confidential Information

# \_\_\_\_\_

I, \_\_\_\_\_, Soc. Sec.# \_\_\_\_\_  
Client Name

Authorize:

1. \_\_\_\_\_  
Name of Doctor/Clinic Date/Initial Fax or Phone #
2. \_\_\_\_\_  
Name Date/Initial Fax or Phone #
3. \_\_\_\_\_  
Name Date/Initial Fax or Phone #
4. \_\_\_\_\_  
Name Date/Initial Fax or Phone #

To release information to: (please check box for applicable WHWC location(s))

**The Wright House Wellness Center (WHWC)**

4301B North IH-35  
Austin, TX 78722  
ph. 512-467-0088  
fx. 512-467-0829

2002-A Manor Rd  
Austin, TX 78722  
ph. 512-236-8901  
fx. 512-236-0365

The following information:

(Please INITIAL ALL highlighted spaces below)

- \_\_\_\_\_ Diagnosis Date
- \_\_\_\_\_ Date(s) of most recent medical visit/check-up (last 6months)
- \_\_\_\_\_ Current Medication(s)/Treatment(s)
- \_\_\_\_\_ Adherence to medical/treatment regimen
- \_\_\_\_\_ Viral load & T-Cell count
- \_\_\_\_\_ Assessments/Medical information/Treatment plans or reviews
- \_\_\_\_\_ Other (Specify) \_\_\_\_\_

The purpose(s) of releasing this information is (are):

- \_\_\_\_\_ Coordinate concurrent services/evaluate treatment
- Continuity of Care
- \_\_\_\_\_ Determine eligibility for services
- Funding requirements
- \_\_\_\_\_ Other (Specify) \_\_\_\_\_

I understand that no disclosure of my records can be made without my written consent, unless otherwise provided by law through exceptions that have been explained to me and that I may revoke this authorization in writing at any time, except to the extent that information has already been released. I understand that information obtained from my client file will be used for research, data collection, and reports.

This release will expire 2 years from the date of client signature: \_\_\_\_\_  
Expiration Date

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

WHWC Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_