



## COMMUNITY HEALTH & WELLNESS PARTNERS

*Care... To Live Life Fully*

### To Our New Patient:

Welcome to Community Health & Wellness Partners (CHWP), where our mission is to provide whole-person, patient-centered health care to anyone and everyone in our community.

Established in 2014, CHWP serves the residents of Logan, Champaign, and surrounding counties with primary health care, including in-office procedures, behavioral health, pharmacy, nutrition, chronic care management, substance use treatment, and social services. Services are available at all primary sites and school-based health centers as identified below, and visits can be in-person or via telehealth.

Many of our providers, both physicians and nurse practitioners, are taking new patients. Our staff can assist you in who is accepting new patients and choosing a provider that will help you meet your health care goals. Please review our website below to learn more about our providers and services offered.

To better prepare for your first visit, we ask you to complete this New Patient Packet in its entirety. This packet requests necessary information needed that will assist us in providing the quality of health care you deserve. Some of the information may feel invasive or personal. The intent of these questions is to support CHWP's declaration that we do not discriminate on any level in providing health care services. If you have any questions or concerns, please do not hesitate to contact us. We are happy to assist you.

CHWP accepts insured, uninsured, under insured and self-pay patients. A sliding-fee scale is offered to those who qualify. Please complete income information on page 1 fully. If you decide to NOT participate in the sliding-fee scale, please checkmark the income ratio applicable to your household and sign the waiver portion on page 2 of the application indicating you choose not to complete the application at this time.

Please note that this packet must be returned to us before your new patient appointment will be scheduled. Once we receive the completed packet, we will contact you with your appointment time. You may drop off this packet at one of our offices mentioned below, send to us by mail, complete online at [www.CHWPCares.org/Resources](http://www.CHWPCares.org/Resources), or return to a hospital staff so they can forward to us.

Thank you for choosing CHWP as your partner in health care! We look forward to meeting you in person soon!

Sincerely,

Tara D. Bair, President/CEO

(Dated: 8/2022)

**Bellefontaine**  
212 E. Columbus Ave., Suite 1  
Bellefontaine, OH 43311

**Indian Lake**  
8200 St. Rt. 366, Suite 1  
Russells Point, OH 43348

**West Liberty**  
4879 US Rt. 68 South  
West Liberty, OH 43357

**Urbana**  
605 Miami St., Suite 100  
Urbana, OH 43078

#### School-Based Health Centers

West Liberty-Salem

Benjamin Logan

Indian Lake

Phone: 937.599.1411 • Fax: 937.599.4128 • [chwpcares.org](http://chwpcares.org)



# COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

## Patient Information Form (Please Print and Complete All Entries)

Please check all services that are requesting:

Primary Medical Care  Behavioral Health  Substance Use/Medication Assisted Treatment

Patient Legal Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex at Birth Female \_\_\_\_\_ Male \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

How Should we Contact you? Phone \_\_\_\_\_ Email \_\_\_\_\_ Postal Mail \_\_\_\_\_ Text \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible party is (Required for patients under the age of 18)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us? Patient \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_ Radio \_\_\_\_\_  
Flyer \_\_\_\_\_ Billboard \_\_\_\_\_ Community Event \_\_\_\_\_ Other \_\_\_\_\_

Do you have internet access? Yes \_\_\_\_\_ No \_\_\_\_\_

### Insurance Information (Please present ALL Insurance Cards and Picture ID)

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Relationship to Patient \_\_\_\_\_ What is your CO Pay \$ \_\_\_\_\_

### Information for Statistical Reporting only

Race: White \_\_\_\_\_ Black/African American \_\_\_\_\_ American Indian/Alaska Native \_\_\_\_\_  
Native Hawaiian \_\_\_\_\_ Other Pacific \_\_\_\_\_ Guamanian or Chamorro \_\_\_\_\_ Samoan \_\_\_\_\_  
Asian Indian \_\_\_\_\_ Chinese \_\_\_\_\_ Filipino \_\_\_\_\_ Japanese \_\_\_\_\_ Korean \_\_\_\_\_ Vietnamese \_\_\_\_\_  
Other Asian \_\_\_\_\_ More than one race \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

Refuse to answer \_\_\_\_\_

Ethnicity: Not Hispanic, Latino/a, or Spanish origin \_\_\_\_\_ Mexican, Mexican American, Chicano/a \_\_\_\_\_  
Puerto Rican \_\_\_\_\_ Cuban \_\_\_\_\_ Another Hispanic, Latino/a, or Spanish origin \_\_\_\_\_

Refuse to answer \_\_\_\_\_



## COMMUNITY HEALTH & WELLNESS PARTNERS

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**Preferred Language:** English \_\_\_\_\_ Spanish \_\_\_\_\_ French \_\_\_\_\_ German \_\_\_\_\_ Russian \_\_\_\_\_ Other \_\_\_\_\_  
Sign Language \_\_\_\_\_

**Marital Status:** Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Legally Separated \_\_\_\_\_  
Widowed \_\_\_\_\_ Life Partner \_\_\_\_\_ Other \_\_\_\_\_

**Gender Identity:** Male \_\_\_\_\_ Female \_\_\_\_\_ Transgender Female \_\_\_\_\_  
Transgender Male \_\_\_\_\_ Other \_\_\_\_\_ Refuse to Report \_\_\_\_\_

**Sexual Orientation:** Straight or Heterosexual \_\_\_\_\_ Lesbian, Gay, or Homosexual \_\_\_\_\_  
Bisexual \_\_\_\_\_ Something Else \_\_\_\_\_ Don't know \_\_\_\_\_ Decline to answer \_\_\_\_\_

**Occupation:** Retired \_\_\_\_\_ Disabled \_\_\_\_\_ Unemployed \_\_\_\_\_ Student \_\_\_\_\_  
Decline to Answer \_\_\_\_\_ Employed \_\_\_\_\_ (list below what you do)

If Employed tell us what you do \_\_\_\_\_

Transportation Needed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes do you have assisted device? \_\_\_\_\_

Are you a Veteran? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you a Migrate Worker? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you Homeless? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, where are you living? Shelter \_\_\_\_\_ Transitional \_\_\_\_\_ Doubling up \_\_\_\_\_

Street \_\_\_\_\_ Other \_\_\_\_\_

### What Advanced Directives do you have?

Living Will \_\_\_\_\_ Durable Power of Attorney\_POA \_\_\_\_\_ Guardian \_\_\_\_\_ Decline to Answer \_\_\_\_\_  
None \_\_\_\_\_

If Yes, please specify who & their relation to you and provide a copy of document to CHWP.

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

### What are your top 3 goals for your first appointment?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



**COMMUNITY HEALTH  
& WELLNESS PARTNERS**  
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**Health History**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

**Past Medical History:** Please check any condition you have been **diagnosed** with by a medical professional/provider.

|                                     |
|-------------------------------------|
| AIDS/HIV                            |
| Alcoholism                          |
| Anemia                              |
| Osteoarthritis of:                  |
| Asthma                              |
| Birth Defects                       |
| Bleeding Disorder: (type if known): |
| Cancer of:                          |
| COPD                                |
| Dementia: (type if known):          |
| Diabetes: Type 1 or Type 2          |

|                             |
|-----------------------------|
| Environmental allergies to: |
| Epilepsy/Seizures           |
| Glaucoma                    |
| Heart Disease               |
| Hyper cholesterol           |
| Hypertension                |
| Thyroid: Hyper or Hydro     |
| Gestational Diabetes        |
| Kidney Disease              |
| Liver Disorder              |
| Migraine                    |
| Stroke                      |

|                        |
|------------------------|
| TIA                    |
| Tuberculosis           |
| Depression             |
| Anxiety                |
| ADHD                   |
| Bipolar Disorder       |
| Borderline Personality |
| Schizophrenia          |
| OTHER:                 |
|                        |
|                        |
|                        |

**Medications:** Please list ALL medications, vitamins, supplements that you are currently taking. **Please bring medications.**

| Medication Name | Dosage (mg) | How often taking per day |
|-----------------|-------------|--------------------------|
|                 |             |                          |
|                 |             |                          |
|                 |             |                          |
|                 |             |                          |
|                 |             |                          |
|                 |             |                          |
|                 |             |                          |

**Allergies:** Please list all medication, food, and health-related allergies and reactions. If reaction not known, write "unknown"

| Allergen: | Reaction: |
|-----------|-----------|
|           |           |
|           |           |
|           |           |

**Hospitalizations:**

| Date | Location | Reason for stay | Length of stay |
|------|----------|-----------------|----------------|
|      |          |                 |                |
|      |          |                 |                |





# COMMUNITY HEALTH & WELLNESS PARTNERS

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### **Surgical History:**

| Date | Type of Surgery | Hospital/Location |
|------|-----------------|-------------------|
|      |                 |                   |
|      |                 |                   |
|      |                 |                   |
|      |                 |                   |
|      |                 |                   |

### **Family History:** Please check box if family member diagnosed with that condition. For cancers, please indicate type.

| Condition         | Mom | Dad | Dad's Dad | Dad's Mom | Mom's Mom | Mom's Dad | Sibling | Child |
|-------------------|-----|-----|-----------|-----------|-----------|-----------|---------|-------|
| Alcoholism        |     |     |           |           |           |           |         |       |
| Dementia          |     |     |           |           |           |           |         |       |
| Anemia            |     |     |           |           |           |           |         |       |
| Asthma            |     |     |           |           |           |           |         |       |
| Birth defects     |     |     |           |           |           |           |         |       |
| Bleeding disorder |     |     |           |           |           |           |         |       |
| Cancer:           |     |     |           |           |           |           |         |       |
| Diabetes          |     |     |           |           |           |           |         |       |
| Heart disease     |     |     |           |           |           |           |         |       |
| High cholesterol  |     |     |           |           |           |           |         |       |
| Stroke            |     |     |           |           |           |           |         |       |
| Heart attack      |     |     |           |           |           |           |         |       |
| Migraine          |     |     |           |           |           |           |         |       |
| Epilepsy          |     |     |           |           |           |           |         |       |
| Glaucoma          |     |     |           |           |           |           |         |       |
| Thyroid issues    |     |     |           |           |           |           |         |       |
| Suicide           |     |     |           |           |           |           |         |       |
| Tuberculosis      |     |     |           |           |           |           |         |       |

### **Social History:**

Have you been sexually active in the last 12 months? Yes \_\_\_ No \_\_\_

Men, Women, or both: \_\_\_\_\_

Have you ever had a sexually transmitted disease? Type: \_\_\_\_\_

Type of contraceptive/protection used: \_\_\_\_\_

### **Female History:**

Date of last period: \_\_\_\_\_ Age at first period: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Any chance you are pregnant now? Yes \_\_\_ No \_\_\_

Any complications during pregnancy? \_\_\_\_\_

Last PAP Smear: \_\_\_\_\_ where performed? \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ where performed? \_\_\_\_\_



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& WELLNESS PARTNERS**

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## CONSENT TO TREAT

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Patient Date of Birth

I for myself do voluntarily consent to medical care, diagnostic procedures, behavioral health counseling, pharmacy, or nutritional counseling services that may be done, requested, or directed by or delegated in the judgment of the attending provider. I understand that I may refuse any services at any time.

I authorize the release of information to all third-party payors or health and social service agencies.

I authorize the release of information to my insurance payor and other health care providers in accordance with Health Insurance Portability and Accountability Act (HIPAA) CFR 42 Part 2.

I authorize the release of information to Medicare and authorize Community Health and Wellness Partners to bill my charges to Medicare.

I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I am responsible for all health center services offered including but not limited to Primary Care, Behavioral Health, Medication Assisted Treatment, Nutrition Counseling, and Pharmacy Services.

Services may be provided by Telehealth, including Video and Phone. If my services are provided by Telehealth, including Video and Phone, I will be responsible for the charges incurred.

I understand that I will be asked to provide proof of income at least once each year, so my charges can be accurately calculated for the sliding fee schedule.

I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Community Health and Wellness Partners when my charges are covered.

I hereby assign, transfer, and set over to Community Health and Wellness Partners all of my rights, title, and interest to my medical reimbursement benefits under my insurance policies.

Community Health and Wellness Partners is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14<sup>th</sup>, 2003.

\_\_\_\_\_  
Signature of Patient, Parent or Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# COMMUNITY HEALTH & WELLNESS PARTNERS

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## HIPAA

Patient Name: (Please Print)

Date of Birth

Initials

### Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original. **Fundraising & Marketing:** Unless you request us not to, we will use your name and address to support our fundraising or marketing efforts. If you do not want to participate in fundraising or marketing efforts, please check off the following box.

Please exclude me from any  Fundraising Purposes  Marketing Purposes

Initials

### Assignment of Benefits:

I acknowledge financial responsibility for all facility and physician fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician for all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at the time of service and the information is not corrected prior to my insurance company's timely filing limit.

Initials

### Medical Records Exchange:

CHWP participates in one or more Health Information Exchanges (HIE). HIEs are electronic networks that securely provide and retrieve access to your health records for a better picture of your health needs. CHWP Providers and other healthcare providers may provide and retrieve access to your health information through an HIE for treatment, payment, or other healthcare operations. As a CHWP patient, you have the ability to opt out of any HIE at any time by notifying a CHWP Associate. This is a voluntary agreement. Unless you advise us differently, your information may be accessed through an HIE by your CHWP provider.

Initials

### Rx-History Consent:

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By initialing this section, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy.

Initials

### Communication Preferences Regarding PHI

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself.

To whom may we talk? Please check the boxes and write in the name(s).

Yes No

Spouse/Significant other: \_\_\_\_\_

Parent/Step-Parent: \_\_\_\_\_

Child/Grandchild: \_\_\_\_\_

Other Person(s): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Initials

### Communication by e-mail or Text

I hereby authorize Community Health and Wellness Partners ("Provider") and other medical professionals or staff members that the Provider has designated to communicate with me, and the Caregivers identified above, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted e-mail, if I have provided an e-mail address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.). I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.

Initials

May we leave a message on:  Home  Cell  Work

Preferred method for appointment reminder (Check all that apply):

Call to Home  Call to Mobile  Text to Mobile

Preferred time for reminder calls:  Morning  Afternoon  Evening

Patient/Representative Signature

Date

**Bellevue**  
211 E. Columbus Ave., Suite 1  
Bellevue, OH 43311

**Indian Lake**  
8200 St. Rt. 366, Suite 1  
Russells Point, OH 43348

**West Liberty**  
4875 US Rt. 68 South  
West Liberty, OH 43357

**Urbana**  
605 Miami St., Suite 100  
Urbana, OH 43078

### School-Based Health Centers

West Liberty-Salem

Benjamin Logan

Indian Lake

Riverside





**Sliding Fee Opportunity**  
*Must be completed prior to service.*

*All patients seeking services are assured they will be served regardless of their ability to pay. No one is refused service because of a lack of financial means to pay so long as they complete and are found eligible in the application process.*

Please sign to either request or decline the Sliding Fee Opportunity:

**REQUEST**

I am requesting to apply for discounted services that are available to patients, family members, or others who are experiencing a financial hardship. Discounts are offered based on family income and size. Our services include Family Medicine and Behavioral Health. Information and forms can be obtained by signing below to receive this information.

**DECLINE**

I choose not to apply for CHWP's Sliding Fee opportunity at this time. I decline my right to apply for the Sliding Fee Discount. I understand I will be responsible for all charges at the time of service. I am aware that if my financial circumstances change, I am not prohibited in the future from applying for the Sliding Fee Program.

**REQUEST**

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**DECLINE**

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Please determine the number of people in your household and check your yearly income range. This information is for generalized reporting regarding the health center.

**NO FINANCIAL INFORMATION IS SHARED.**

**NUMBER OF PEOPLE IN YOUR HOUSEHOLD: \_\_\_\_\_**

| Range 1             | Range 2                  | Range 3                  | Range 4                  | Range 5                  | Range 6       |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------|
| ( ) \$0 to \$15,000 | ( ) \$15,001 to \$30,000 | ( ) \$30,001 to \$45,000 | ( ) \$45,001 to \$60,000 | ( ) \$60,001 to \$75,000 | ( ) \$75,001+ |

**Bellefontaine**  
212 E. Columbus Ave., Suite 1  
Bellefontaine, OH 43311

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West Liberty, OH 43357

**Urbana**  
605 Miami St., Suite 100  
Urbana, OH 43078

Revised: 2/2024

**School-Based Health Centers**

West Liberty-Salem      Benjamin Logan      Indian Lake      Riverside





**COMMUNITY HEALTH  
& WELLNESS PARTNERS**

*Care... To Live Life Fully*

Phone: 937-599-1411

Fax: 937-599-4128

Email: [documents@chwplc.org](mailto:documents@chwplc.org)

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Name of Person completing Form: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I, authorize Community Health & Wellness Partners (CHWP) to request, use, and/or disclose Protected Health Information as indicated below.

Exchange Information With       Request Information From       Send Information To

|   |
|---|
| <b>Name of the party requesting or receiving information:</b> |
| <b>Address:</b>   |
| <b>City/State/Zip:</b>  |
| <b>Phone/Fax:</b>   |
| <b>Email Address:</b>   |

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. In order to revoke the Authorization for Release of Information, I will contact the Community Health and Wellness Partners' Health Information Management Department.

This Authorization will remain in effect for one year after I sign and date this form unless I specify an EARLIER expiration date in the space provided. Early Expiration Date: \_\_\_\_\_

**Notice:** This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such information by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

**(These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)**



**COMMUNITY HEALTH & WELLNESS PARTNERS**

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**Amount of Information to be Disclosed:**

- Information covering all dates of service (past, present, future)
- Information covering the following specified date range: \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)
- Other (specify the date of treatment or admission/discharge): Date: \_\_\_\_\_

**The purpose/need of this request is:**

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

The following **INITIALED** information may be provided by mail, fax, in person, verbally, or by secure email:

\_\_\_\_\_ All of my Physical Health Information contained in the description boxes below:

\_\_\_\_\_ All of my Mental Health Information contained in the description boxes below:

\_\_\_\_\_ All of my Substance Use Information contained in the description boxes below:

**INITIAL beside the information to be shared/requested**

- |                                       |   |
|---------------------------------------|---|
| _____ Assessment Information/ Results | _____ Progress Notes/Clinical Notes                 |
| _____ Care Plan/Review                | _____ Laboratory Results/Drug Screen Results        |
| _____ Treatment Recommendation        | _____ Medication History                            |
| _____ Transfer/Discharge Summary      | _____ Hepatitis C Results                           |
| _____ Financial Information           | _____ HIV Results or AIDS/ARC Diagnosis Information |
| _____ Psychiatric Evaluation          | _____ CHWP Scheduled Appointment                    |
| _____ Treatment Diagnosis             | _____ CHWP Attended Appointment                     |
| _____ Treatment Progress              | _____ Other: _____                                  |

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Signature of the Patient**

\_\_\_\_\_  
**Date of Patient Signature**

\_\_\_\_\_  
**Print Name of the Person Authorized to Sign for the Patient**

\_\_\_\_\_  
**Describe Authority to Sign for Patient**

\_\_\_\_\_  
**Signature of the Person Authorized to Sign for the Patient**

\_\_\_\_\_  
**Date of Signature**

*CHWP Authorization for Release of Information, 11/2023*

For administrative use only:

**Completed by:**

**Needs Faxed?**

Yes \_\_\_ or No \_\_\_

**Preferred Delivery Method**

Paper \_\_\_ Fax \_\_\_ Email \_\_\_

Other: \_\_\_\_\_

**Date Released:**

\_\_\_\_\_