WORTHY WOMEN TRANSFORMATION (WWT)

WWT, 1001 Maple Ave.
La Porte, IN 46350
219-405-7006 worthy@wwtransform.org

Release and Disclosure of Information

I,_____, authorize the following individuals, medical providers and agencies to share, provide, release, communicate about, discuss and exchange information, records and documents,
regarding my history, my medical, psychological and mental records, and any other appropriate data with WWT personnel. This release to WWT personnel includes, but is not limited to, the release, delivery and/or disclosure of facts, information and documents relating to my medical and/or psychological diagnosis and treatment, records, reports, x-rays, photo static copies and/or electronic data. The purpose and need for disclosure **of information** is to provide collaboration with the **listed** entities regarding my attendance, progress, and attitude toward my evaluation and required treatment. The extent of necessary information to be disclosed includes:

1. Attendance
2. Prognosis
3. Results of Drug / Alcohol Screen
4. Required Services
5. Completion
6. _____

I understand that the provision of services by WWT is not contingent upon my signing this document. I understand that I may revoke this authorization at any time except to the extent that action has already been taken using this authorization. This authorization will be valid during my application process, during my residency at Worthy Women Transformation and for 365 days after discharge/termination of services with Worthy Women Transformation.
Examples of Services needed: Resident Family members (up to 4(FM), Probation & Parole Officer, Doctor(s), Pharmacy, Counselor, WWT Personnel, Religious Leader, Spouse, Employer)

1. FM _____
2. FM_____
3. FM_____
4. FM _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I understand that the recipients of this information may re-disclose it only in connection with their official duties.
I have received a copy of this signed form.

(A photocopy of this completed form shall be as valid as the original) All blank lines must be filled in or N/A written on it.

_____ _____
Resident Signature Date

_____ _____
Staff Witness Signature Date