CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____ / _____ / _____

I request that my protected health information (PHI) be: (*Please Circle)* Disclosed To / Obtained From:

Name _____

Address_____ Phone Number _____

City_____ Fax Number _____

State _____ Zip _____ Email Address_____

Information to be released: (*Check all applicable categories*)

❑ Verbal Exchange of Info ❑ Alcohol/Drug Treatment/Evaluation ❑ Psychological Testing Evaluations

❑ Diagnosis ❑ Medication List ❑ Payments / Billing

❑ Treatment Plans ❑ Scheduling ❑ Progress Notes

Disclosures Requiring Special Consent: In Compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information. I am authorizing that the following information be disclosed: Mental/Behavioral Health, Developmental Disabilities, Drug/Alcohol Abuse Treatment, and HIV/AIDS.

Covering the period of healthcare from:

Specific Date (s): _____ to _____ ***OR*** All Dates of Service (***Circle)***

Provider(s) Name: _____

Purpose for Requesting Information:

❑ Coordination of Care ❑ Spouse ❑ Legal ❑ Parent

❑ Insurance/Work Comp ❑ Personal / Self ❑ Other _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: *I understand that this authorization may be revoked by me at any time (except when the facility has already acted in reliance on it) by written notice to the appropriate Medical Records Department. I have the right to inspect and receive a copy of the material to be disclosed and receive a copy of the informed consent. When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPAA (Health Information Portability and Accountability Act of 1996) regulations and may be subject to re-disclosure by the Recipient and the information may no longer be protected. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment or utilize insurance for payment.*

This authorization will remain in effect for one year after the date of signature unless you specify otherwise and includes future records generated after the date of signing unless otherwise specified.

❑ Other time period. Specify_____ ❑ Do Not include future records generated after the date of signing

PATIENT SIGNATURE_____ TODAY'S DATE _____

(14 AND OLDER)

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE _____ TODAY'S DATE _____

RELATIONSHIP TO PATIENT_____

IF APPLICABLE:

Prohibition of Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and Wisconsin Statute 51.30) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

**Baeten Counseling, Delta Center and New Directions are a division of Sherman Counseling.*
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