Comprehensive Counseling Services
101 E Pier St, Ste 2, Port Washington, WI 53074
Phone: 262-284-5789
Fax: 262-284-5907

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

(Name of Treating Provider)

(Patient Name) / (Previous Name) (DOB) (MR#)

❒ I hereby authorize the above noted facility to release records of my treatment (i.e. send my records to the person/institution named below: **OR**
❒ I hereby authorize the above noted facility to obtain records of my treatment from (i.e. receive my records) from the person/institution below:

Name: _____ Telephone # _____

Address: _____ Fax # _____

The purpose for releasing/obtaining these records is: ❒ To aid in the continuity of my care **OR** ❒ Specify _____

I understand that the information may include diagnosis, prognoses, and/or treatment for physical and emotional illness, including treatment of alcohol and/or drug abuse and HIV results. Records of child and adolescent patients may include reference to parental emotional illness, including the treatment of alcohol and drug abuse.

The specific and relevant information to be released or obtained:

❒ Discharge Summary
❒ History & Physical
❒ Verbal Information
❒ Psychiatric Evaluation
❒ Referral letter & Transfer Form
❒ Psychosocial & Chemical Hx
❒ OP Assessment/Evaluations
❒ Progress Notes
❒ Aftercare Plan
❒ Lab Data

Child & Adolescent Forms:

❒ Patient Cover Letter to School
❒ M-Team Reports
❒ Immunization Records
❒ Academic, attendance, behaviors info

❒ Other _____

Treatment Time Period (list dates): _____

I understand that the above facility will not condition treatment or payment on the signing of this authorization except where the provision of healthcare is solely for the purpose of creating health care information for disclosure to a third party. I have the right to revoke this authorization (by written notification) except to the extent that information was released, as authorized, prior to notice of the revocation. I understand that I do not have the right to revoke this Authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. This consent will remain in effect until the following date or event 1 year from signature date and in all cases expires in one (1) year.

This information has been disclosed from records whose confidentiality is protected by Federal (42 CFR Part 2) and Wisconsin (§51.30) laws. These laws prohibit redisclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations and statutes. A general authorization for release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE.

I understand I may inspect and receive a copy of the disclosed information. I have read all of the above and understand the nature of this release.

CHECK ONE OF THE FOLLOWING:
❒ I am the patient.
❒ I am the parent / legal guardian of the above named minor child and I represent that I have not been denied access to my child by a court of law and/or denied periods of physical placement with my child.
❒ I am the next-of-kin of the above named deceased patient (proof of death required.)
❒ I am the above named patient's Durable Power of Attorney for Healthcare Agent (proof and activation of DPOA required.)

Date: _____ Signature: _____

Date: _____ Witness: _____

COMPREHENSIVE COUNSELING RESERVES THE RIGHT TO CHARGE FOR COPYING MEDICAL RECORDS

FAX IS AS GOOD AS ORIGINAL

For information released to another organization, identify date information released: _____