Authorization to Release Information

Introduction: This authorization form is intended to be in conformance with Section 49.53, 51.30(2), 51.30(4)(d), and 146.82 Wisconsin Statues, Sections DHS 35, 75, 92.03(3)(d), 92.05, and 92.06, Wisconsin Administrative codes, and 42 CFR Part 1 and 45, CFR Part 160 and 164, and Federal Regulations. I, _____, voluntarily consent to the disclosure of the specific information listed below, by written, faxed, electronic, or verbal communication, regarding patient _____, date of birth _____, by/to Shorehaven Behavioral Health, Inc., 3900 W. Brown Deer Rd., Suite 200, Brown Deer, WI 53209, (414) 540-2170, fax (414) 540-2171 by/to _____.

Purpose. The purpose or need for this disclosure is for:

- ☐ **Treatment:** Aiding in diagnosis and treatment planning, continuity of care with current or previous providers
- ☐ **Payment:** Insurance, billing, and/or fees
- ☐ **Healthcare/Other Services:** Medical, educational, or vocational planning, communications, services, disability claims, insurance applications, legal

Information. I understand I may request a Shorehaven privacy policies notice. I understand I may restrict the information to be released and its use. I am aware of the information to be released and agree to its disclosure. I authorize the disclosure for:

- ☐ All medical records
- ☐ Records within a range of dates: _____
- ☐ Most recent two years of chart/progress notes, labs, special tests, D/C summary
- ☐ Diagnosis, prognosis, reports of progress, including hospitalization, for physical and/or emotional disorders including alcohol or drug abuse
- ☐ Psychiatric, social, psychological, school reports, observations and health evaluations
- ☐ Court-ordered psychiatric or psychological evaluations, Protective Services Reports, Stipulations, and CHIPS petitions
- ☐ Other: _____

Exclusions. Exclude the following information from release: _____.

Right/Fee to Copy. You have the right to inspect or have a copy of the materials disclosed and to receive a copy of this document. Uniform, reasonable fee may be charged for a copy of records. The fee may be reduced in accordance with agency policy.

Revocation. This consent may be revoked by written notice at any time to Shorehaven Behavioral Health, Inc., or to the releasing party to this release, except to the extent the provider of information has already acted upon it. Action taken on this authorization prior to the date of revocation is legal and binding. If this release has been sent to or executed by the other party, copy of revocation will be sent to the releasing facility. I may receive a copy of the revocation. In any case, consent expires 15 months from the date below, or earlier if noted here: _____.

Disclaimer to Accompany Disclosures. For alcohol/drug patient treatment records, check here: ☐ . When Shorehaven releases information, the following disclaimer applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Re-Release. This information may not be further disclosed by the recipient without my permission to re-release:

A. When Shorehaven receives records from another provider of services, and these records are in my Shorehaven file, Shorehaven ☐ may ☐ may not re-release the information from _____.

B. The information disclosed by Shorehaven with this Authorization ☐ may ☐ may not be re-released by the recipient of the information.

C. Child Welfare/Protection agencies Authorization ☐ may ☐ may not re-release to Shorehaven any CHIPS- or court-generated reports.

Recordings. For audio/visual recordings, initial here: _____. I give permission for electronic recording of our therapy session(s) and the use of this recorded material for the purposes of consultation by our therapist. The therapist may use this recorded material outside of Shorehaven for educational purposes, and these uses have been explained to me and I agree the counselor may retain this recording for this use.

Services. Services may not be denied or restricted due to the denial of authorization to release information except insofar as denial of this authorization may in the judgment of the clinic or clinician compromise the ability of the clinic to provide effective services or to bill for services. Signer may request a copy of this completed document. A photocopy of this form is an acceptable substitute for the original.

_____ _____

Client Signature Effective on Date Signed

_____ _____

Person Authorized to Sign for Client Relationship