ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374 **Mailing Address:** PO Box 959, Stevens Point, WI 54481 **Fax:** 715-952-4995
Email: office@advocatepsychotherapyservices.com **Website:** www.advocatepsychotherapyservices.com

Authorization for Release of Patient-Identifiable Health Information

Patient Name: _____ DOB:_____

I hereby request and authorize that my therapist, _____,with Advocate Psychotherapy Services LLC, to do the following concerning my personal healthcare information (PHI):

_____To disclose to _____Receive from _____Exchange with

Name_____

Address_____

City/State/Zip_____

The following specific information from my record for the dates of treatment: _____

Type of treatment: _____Mental Health_____ Other (specify): _____

INFORMATION TO BE RELEASED:

_____ Verbal Information _____ Intake/Assessment _____ Discharge Summary/Note

_____ Progress Notes _____ Treatment Plan _____ Aftercare Plan

REASON FOR RELEASE: _____

I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under ss. HFS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information**. I may revoke this authorization in writing at any time except to the extent that information already released pursuant to this consent cannot be recalled.** [45 CFR 164.508(c)(2)(1)] Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination of revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (42 CFR Part 2.35). **I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.** If I have questions about disclosures of my PHI, I can contact the Privacy Officer at the agency listed above.

Notice to Person / Agency Receiving This Release: This authorization form is intended to be in conformance with Section 51.30 (4) (d) Wisconsin Statues; Sections HSS 92.03 (3) (d), 92.05, 92.06 Wisconsin Administrative Codes; Sections 49.53, 51.30 (2) 146.82 WI Status; title 45 Code of Federal Regulations, Sections 205.50, and 205.59.This information has been disclosed to you) from records protected by Federal confidentiality rules (42 CFR Part 2). ***THEREFORE***, the 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. **This authorization is effective for ONE YEAR from the date of signing or as specified by the client (but no longer than one year).**

Signed Patient/Client/Resident_____ Date:_____

Signed Parent/Guardian/Other (specify)_____ Date:_____

Signed Witness_____Date:_____

(Fax/Copy effective as original)