

**THE PSYCHOLOGY CLINIC, Inc.**  
**CONSENT FOR RELEASE OF INFORMATION**

**1 I hereby authorize:**

**The Psychology Clinic, Inc.**  
**137 3rd Avenue, Baraboo, WI 53913**  
**(608) 448-2797 FAX (608) 448-2799**

**2**

**To release information to:**  **To obtain information from**

(Checking both authorizes an exchange of information between the agencies/individual listed.)

**Agency and/or Individual** \_\_\_\_\_

**Street/City/State/Zip** \_\_\_\_\_

**Phone#/Fax#** \_\_\_\_\_

**3 From the records of:**

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_

Other names used: \_\_\_\_\_

**4 Purpose for disclosure:** To facilitate mental health and/or AODA treatment

Other: \_\_\_\_\_

**5 Types of treatment information to be disclosed:**

- |  |   |
|--|---|
| <input type="checkbox"/> Verbal and/or Written | <input type="checkbox"/> Medical                    |
| <input type="checkbox"/> Mental Health         | <input type="checkbox"/> Developmental Disabilities |
| <input type="checkbox"/> AODA                  |   |

**Specific information to be disclosed:**

- |  |   |
|--|---|
| <input type="checkbox"/> Intakes           | <input type="checkbox"/> Terminations                 |
| <input type="checkbox"/> Treatment Plans   | <input type="checkbox"/> Psychiatric Evaluations      |
| <input type="checkbox"/> Treatment Reviews | <input type="checkbox"/> Hospital Discharge Summaries |
| <input type="checkbox"/> Progress Notes    |   |

**6 I understand that:**

(a) My records are protected under State and Federal regulations governing confidentiality:

\* Mental Health - Sec 51.30, Wis Stats & DHS 92, Wis Admin Code

\* Alcohol & Other Drug Abuse, 42 OFR Pt 2; Sec 51:30, Wis Stats/DHS 92 Wis Admin Code

\* Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45 CFR pts 160, 164

(b) I will receive a copy of this form and can receive a copy of the material disclosed and that information cannot be disclosed further without my written consent unless otherwise provided for in the regulations.

(c) I may revoke this consent in writing at any time by giving notice to The Psychology Clinic, Inc., except to the extent that information has already been disclosed based on this release.

(d) Generally, I am not required to sign this form in order to receive services at The Psychology Clinic, Inc. However, there are limited circumstances where treatment may be denied unless there is a signed release.

**7 This consent (unless revoked earlier) expires on: \_\_\_\_\_**

(Date, event or condition upon which expiration occurs - not to exceed one year from date of signature below.)

\_\_\_\_\_  
**Client/Legal Representative signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Provider Representative signature**

\_\_\_\_\_  
**Date**