THE PSYCHOLOGY CLINIC, Inc.

CONSENT FOR RELEASE OF INFORMATION

1 **I hereby authorize:** **The Psychology Clinic, Inc.**
1190 Prairie St., Prairie du Sac, WI 53578
(608) 370-6551 FAX (608) 370-6554

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:** Verbal and/or Written:
Mental Health AODA Medical Developmental Disabilities

Specific information to be disclosed: Intakes Treatment Plans Treatment Reviews Progress Notes Terminations Psychiatric Evaluations Hospital Discharge Summaries

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**