WISE MIND
MENTAL HEALTH CLINIC, LLC

601 E 3rd St
Marshfield WI 54449
715-384-0080 Fax: 715-384-0090
www.wisemindclinic.com

Authorization for Release of Information

Patient Name: _____DOB:_____

Address: _____

Phone Number: _____

I authorize a release of information for Wise Mind Mental Health Clinic, LLC

____ To Provide Information To:

____ To Receive Information From:

____ To Exchange Information With:

:

Organization Name:_____

Name of Person/Department: _____

Address: _____

Phone: _____ Fax: _____

The type of information to be disclosed:

____Evaluation
____Diagnosis
____Treatment Plan
____Course of Treatment
____Correspondence
____ Appointment Information
____Medical/Hospital Records
____Psychological/Medical Test Results
____Mental Health Record Summary
____Psychotherapy Notes*
____ Alcohol or Drug Treatment Information
____Other_____

**Psychotherapy notes are afforded special protection under Hipaa, and may be released or retained at therapist discretion.*

The purpose of such disclosure:

____ Ongoing Treatment
____ Consultation
____ Transfer of Care
____ Coordination of Care
____ Work or School Needs
____ Social Services Coordination
____ Medical Care
____ Evaluation
____ Legal Purposes or Disability
____ Appointment Coordination
____ Personal
____ Other _____

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The designated information about me may be transmitted:

____By Fax ____By Email/Electronic file transfer
____Verbally/By Phone or In Person ____In Writing
____In Any Format ____Other _____

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties mentioned here from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that I have the right to revoke this release in writing at any time. I realize in the event that information has already been released by valid authorization cannot be retracted. I also understand that the disclosure of health information without my authorization may be allowed or required by law in some instances.

The information provided by a patient during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in state law for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

I understand that HIPAA generally allows the right to receive and inspect a copy of the records being shared, however, state law permits the restriction of this right for mental health treatment records under certain circumstances.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____
Signature of Patient (14 years and older) or Personal Representative Date

_____
Signature of Parent Date

____ Copy Accepted by Patient ____Copy Offered to and Declined by Patient