Consent To Release or Obtain Information

Patient: ____ Date of Birth: _______________

I hereby authorize: **Community Counseling Center of Madison, WI, Inc.** to: (Please check at least one)

__ Disclose protected health information to: ___ Receive protected health information from:

__ Exchange protected health information with:

Name: ____

Address: ____

____

Phone #: ____

Please check Specific Records Authorized for Release, Receipt or Exchange:

___ School Transcripts/Teacher Evaluations
___ Psychiatric Evaluations
___ Psychotherapy Intake & Discharge Summaries
___ Therapy Progress Notes
___ Medical Reports
___ Psychological Tests/Reports
___ Alcohol/Drug Abuse Treatment
___ Other (Specify) _________________________

Records from the time period: ___________________________ To: ___________________________

Records after the date of my signature **MAY** or **MAY NOT** be released. (Please circle one.)

I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouses that must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: ___________________________________

I understand that I have the right to inspect and receive a copy of the released information (upon payment of any applicable fee), and that I may receive a copy of this consent form. I understand this consent may be revoked except to the extent that action has already been taken in reliance thereon. I understand that this authorization shall be valid for one year from date of signature unless otherwise stated below. I authorize disclosure of records to the Agency/Individual specified above. I am not required to sign this form and may refuse to do so. Except as permitted under applicable law, Community Counseling Center may not deny me services because I refuse to sign.

Alternate date if not one year ____

Signature of Patient: ____ Date: ___________________

Parent/Guardian: ____ Date: ___________________

Witness: ____ Date: ___________________