**AUTHORIZATION / RELEASE OF INFORMATION**

To Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Client Name (print):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth: **\_\_\_\_\_\_\_\_\_\_\_**

I authorize **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (person/agency) to use or disclose the following information:

| INFORMATION TYPE | AUTHORIZED: | DISCLOSED: |
| --- | --- | --- |
| Outpatient Clinical Records | **▢** | **▢** |
| Discharge Summary | **▢** | **▢** |
| Psychological or Psychiatric Evaluation Reports | **▢** | **▢** |
| Summary of Medical History | **▢** | **▢** |
| Billing Records | **▢** | **▢** |
| Medication History | **▢** | **▢** |
| Communicate Clinical Information Verbally to Each Other | **▢** | **▢** |
| Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **▢** | **▢** |

To:   \_\_\_\_\_\_ \_   (person/agency)

For service/treatment dates: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The information will be used for the following purposes:

I understand and agree that, unless withdrawn, this authorization will expire *1 year* from date of signature below:

Signature of client or personal representative Date

Printed name of client or representative Relationship to the Client

Please Return To: **Shore Counseling and Consulting Clinic**

2600 N. Mayfair Rd., Suite 650, Wauwatosa, WI 53226

Fax: (414) 771-9543