Authorization for Release of Information

P.O. Box 22308, Green Bay, WI 54305-2308
920-436-6800 • www.familyservicesnew.org

Client Number

Client Name

Date of Birth

AUTHORIZES: ☐ Release to ☐ Obtain from ☐ Mutual release between

FAMILY SERVICES OF NORTHEAST WI
P.O. BOX 22308
GREEN BAY, WI 54305-2308
Phone (920) 436-6800
Fax (920)432-5966

Agency/Program/ Person

Address/City/Zip

Phone ( ) - fax ( ) -

I understand that the specific type of information to be disclosed includes: Dates of service to include: _____to_____

☐ Mental Health Records ☐ Psychiatric Reports ☐ Psychological Reports
☐ AODA Assessment & Treatment ☐ Medical Records ☐ Multi-Disciplinary Team Reports
☐ Discharge Summary/Plan ☐ School Records including attendance
☐ Other (specify below): _____

I understand that the information disclosed may include reference to or treatment of **alcohol/drug abuse or mental/behavioral health information.** In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to: ☐ (AIDS/HIV related information) ☐ (Other) _____

The purpose or need for this disclosure is: (Check all that apply)

☐ Further assessment, treatment or care ☐ Research ☐ Care Coordination
☐ Other _____

This authorization includes consent to release information verbally from these records: ☐ Yes ☐ No ☐ Other _____

Expiration Date of this Authorization: If not previously revoked, this consent will terminate **in one year or:**
☐ after the above information has been released ☐ on specific date or event _____.

I understand that this authorization is voluntary and I need not sign this form in order to assure treatment. ** I also understand that I have the right to inspect and/or receive a copy of the information to be disclosed if I sign a separate authorization to myself to receive the copy. I understand that the information I authorize to be released may be re-disclosed by the recipient of the records only if allowed by law and that **I have the right to revoke this authorization, in writing at any time by contacting my therapist or medical records at (920) 436-6800**.

By signing this form, I attest that I understand and agree with the content of this form.

_____ _____/_____/_____
(Client) (Date)

_____ _____/_____/_____
(Parent / Legal Guardian / Authorized. Representative) (Date)

_____ _____/_____/_____
(Witness/Relationship/Department) (Date)

For Office Use:
❒ I.D. Verified

OC 411

*** * * YOU MAY REFUSE TO SIGN THIS FORM * * ***
*** * A COPY IS AS VALID AS THE ORGINAL * * ***

INSTRUCTIONS FOR COMPLETING RELEASE OF INFORMATION

1. Enter the Client Number

2. Enter the client's name and date of birth.

3. Check appropriate boxes (indicating release to, obtain from, or mutual release).

4. Fill in name of agency/person who is to receive information from Family Services or mutual release with Family Services.

5. Specify the exact dates (or range of dates) of treatment that records are being requested for.

6. Indicate the type(s) of information being released. If other, fill in the blank to describe.

7. Indicate the purpose or reason for disclosing the requested information. If other, fill in the blank to describe.

8. Indicate if permissible to verbally release the information specified in item #6 above.

9. If you wish to specify a date that the Release will terminate, indicate the date at the end of the paragraph regarding revocation with a maximum of one year. If no date is indicated, the Release will terminate one year following the date the Release is signed.

10. The properly authorized person should sign and date the Release. Please review your program guidelines for age of consent needed to sign release.

11. The Release should be witnessed and dated by the witness at the same time #10 above is signed.