Arbor Mental Health Center
AUTHORIZATION OF DISCLOSURE/RELEASE OF INFORMATION

NAME _____ DOB _____

I hereby request and authorize: Arbor Mental Health Center, LLC To:

____ Disclose ____ Receive from ____ Exchange with (Check one)

Name: _____

Address: _____

City/State/Zip: _____

The following specific information from my records: Dates of Treatment: _____

Type of Treatment: _____ Mental Health _____ Alcohol/Drug _____Other (Specify)

Description of Information to be Disclosed: ____ Verbal _____ Written ____E-mail ____Fax

_____ Assessment Summary
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ After Care Plan
_____ Case Notes
_____ Other (Specify) _____

Purpose: The purpose of this disclosure of information is to**:** _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Chief of Operations at Arbor Mental Health Center 500 N. 3rd St. Ste. 220, Wausau, WI. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Authorization of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (423CFR Part 2.35).

Conditions: I further understand that Arbor Mental Health Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: information will not be disclosed which may result in difficulty treating me or _____.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I understand that I am entitled to a copy of this release and the information released.

Expiration: This authorization is effective for one (1) year from the date of signing or as specified by this condition stated: (no longer than one year): _____

_____ _____ _____ _____

Signature of Patient/Client Date Signature of Parent or Guardian Date

_____Check here if patient/client/guardian refuses to sign authorization

_____

Signature of Staff Witness Date

This information has been disclosed to you from records protected by federal confidentiality rules (42CFR.Part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42CFR.Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse consumer. (Copy effective as original).