Forest County Potawatomi Health and Wellness Center
PO Box 396
Crandon, WI 54520
Phone: 715-478-4332 Fax: 715-478-4493

AUTHORIZATION FOR RELEASE OF PHI / BEHAVIORAL HEALTH

Patient:

_____

Last Name First Name, MI Date of Birth SS#

Authorize Records Release from: Information released To:

_____ _____
Name Name

_____ _____
Street Address Street Address

_____ _____
City State Zip City State Zip

Information to be released: (Initial only those applicable)
___Verbal Information ___Psychiatric Evaluations ___Treatment Plan
___Assessment Results ___Psychological Evaluations ___Discharge Summary
Other:_____

For Purpose of such disclosure: _____

Dates Records Requested: _____

I understand that this consent is revocable at any time in writing, except to the extent that action has already been take. This authorization automatically expires on date: _____.
The authorization may only be revoked by completing our Authorization Revocation Form. You do not have the right to revoke this Authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy.
I understand that information used or disclosed as a result of this Authorization may be further used or disclosed by someone who obtains that information and therefore may no longer be protected by Federal Privacy Laws. I acknowledge that I have signed this authorization.
You may refuse to sign the authorization and the Behavioral Health Provider will not receive direst or indirect payment as a result of this requested use or disclosure. Except to the extent allowed by law, the Behavioral Health Provider will not condition treatment by you not signing this authorization form.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Legal Representative if a minor Date

_____ _____
Witness Signature Date

NOTE TO RELEASE RECIPENT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further discloser of it without the specific written consent of the person to whom it pertains: or as otherwise permitted by such regulations. A general requirement for the release of medical or otherwise is NOT sufficient for this purpose.

UNLESS OTHERWISE REQUIRED BY LAW YOUR RECORDS CANNOT BE RELEASED WITH OUT YOUR WRITTEN CONSENT.

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