

ELMERGREEN ASSOCIATES, INC.

Phone: 715/845-7175

Fax: 715/845-7142

Authorization for Release of Patient-Identifiable Health Information

Patient Name _____ DOB _____ SS# _____
(list maiden name/other names used)

I hereby request and authorize Elmergreen Associates: 114 Grand Ave., Wausau, WI 54403 to

Disclose to _____ Receive from _____ Exchange with _____

Name _____

Address _____

City/State/Zip _____

the following specific information from my records: Dates of treatment _____
Type of treatment: Mental Health _____ Alcohol/Drug _____ or
Other (Specify) _____

INFORMATION TO BE RELEASED

Verbal Information _____ Psychiatric Eval _____ Discharge Summary/Notes _____

Progress Notes _____ Treatment Plan _____ Psychological Eval _____

Dietician Notes _____ M.D. Notes _____ Assessment Summary _____

Other ("all records" not acceptable) _____

The purpose of such disclosure is _____

I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under **ss.HFS 92.05 and 92.06**. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this Authorization, in writing, at any time except to the extent that information already released pursuant to this consent cannot be recalled. **{45 CFR 164.508(c)(2)(1)}**. 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 any release from confinement, Probation or Parole, or other proceedings under which I have been mandated into for treatment.

This authorization is effective for 6 months from the date of signing or as specified by the condition stated (no longer than one (1) year: _____)

Patient/Client Signature _____ Date _____

Parent/Guardian/Other Signature _____ Date _____

Witness Signature _____ Date _____