SHERMAN COUNSELING

W6144 Areotech Dr. Appleton WI 54914 / PHONE : 920.733.2065 FAX : 920.733.6565

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB: _____
(Name of Client)

authorize Sherman Counseling, LLC to **disclose to / release from** (circle one or both):

_____
(Name of Person and/or Organization)

_____
(Address, City, State, Zip)

_____ _____
(Phone) *(Fax)*

the following information:
__ Name
__ Intake Data
__ Impressions
__ Diagnosis
__ Treatment Plans
__ Discharge Information
__ Other : _____

for the following purpose(s):
__ To Coordinate Services
__ To Facilitate Treatment Planning
__ Other : _____

____ I understand that this authorization may be revoked by me at anytime (except that the facility has already acted in reliance on it) by written notice to the appropriate Medical Records Department. I have the right to inspect and receive a copy of the material to be disclosed and received a copy of the informed consent. This consent will remain in effect until the above request is processed or unless otherwise specified. When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPPA (Health Insurance Portability and Accountability Act of 1996) regulations. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

____ I understand that my records are protected under Federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance of it and that in any event, this consent expires automatically as described below. This release expires upon the fulfillment of the purpose for which this release was enacted and in any event specifically expires on:

Date of Expiration : _____

____ Prohibition of Disclosure: This information has been has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and Wisconsin Statute 51.30) The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. I understand I may inspect and receive a copy of disclosed information

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will

Dated this _____day of _____, 20____

_____
(Signature of Client / Parent / Legal Guardian / Authorized Representative, if required)