Crossroads Counseling Center
17 South River Street, Suite 254
Janesville, WI 53548
Phone (608) 755-5260 Fax (608) 755-5267

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client:_____ **DOB:**_____

Authorizes:

_____
Name of Health Care Provider/Other

_____
Street Address

_____
City, State, Zip Code

Release Of Protected Health Information To:

Crossroads Counseling Center
Name of Health Care Provider/Plan/Other

17 South River Street, Suite 254
Street Address

Janesville, WI 53548
City, State, Zip Code

Authorizes:

Crossroads Counseling Center
Name of Health Care Provider/Plan/Other

17 S. River Street, Suite 254
Street Address

Janesville, WI 53548
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Release Of Protected Health Information To:

_____
Name of Health Care Provider/Other

_____
Street Address

_____
City, State, Zip Code

Information To Be Released:

_____Medical records (inpatient)	_____Psychiatric evaluation	_____ Psychiatric (inpatient) evaluation and discharge summaries
_____Medical records (outpatient)	_____All Psychiatric treatment notes	_____ M-team evaluations, IEP's and school behavior records
_____Laboratory results/reports	_____Psychotherapy notes	_____ Phone contact with school personnel as needed
_____ Psychiatric Progress Notes	_____Psychological testing/evaluation	_____AODA evaluation/treatment
_____ Phone contact	_____Other (Specify):_____	

Dates of service: From_____ **To**_____

Purpose for Need of Disclosure: (Check applicable categories)

_____Further Medical Care	_____ Legal Investigation or Action	_____ Insurance Eligibility/Benefits
_____ Coordination of services	_____Other (Specify):_____	

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified:_____.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization: Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Expiration Date: I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. Unless revoked earlier, or otherwise specified below, this consent will expire in twelve (12) months from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client: _____ **Date Signed:**_____

Signature of Parent, Guardian or Authorized Person:_____ **Date Signed:** _____

If signed by person other than patient, state relationship and authority to do so.
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Parent of minor ☐ Power of Attorney ☐ Next of kin (Spouse of living) ☐ Legal guardian (Attach proof)

Witness initials:_____