Winding Rivers Counseling, LLC
Consent to Disclose Confidential Information

Patient Name: _____ Birth Date: _____ Phone: _____

_____

Address City State Zip

Authorizes:
Winding Rivers Counseling LLC

To: ☐Release to: ☐Receive from: ☐Verbally exchange with:

Name of Organization/Individual _____

_____

Address City State Zip

_____

Telephone Fax

Records to be Disclosed (Please Check):

☐ Mental Health Treatment Records	☐ Educational Records
☐ Initial/Intake Assessment	☐ Standardized Test Scores
☐ Progress Notes	☐ Teacher/Counselor Records
☐ Treatment Plan	☐ IEP Plans
☐ Discharge Summary	☐ Human Services Records
☐Medical Evaluation/Health Records	☐ Acknowledgment of Admission
☐ Psychiatric Evaluations	☐ Verbal/Written Communication
☐ Psychological Evaluations/Test Scores	☐ Appointment Information
☐ Alcohol and Drug Treatment Records	☐ Other _____

Time Period for which records are requested: From_____ To_____ ☐ All

Reason for Release (please check all that apply): ☐ Coordinating Care/Treatment ☐ Transfer of Care ☐ Personal
☐ Case Management ☐ Billing, Collection, Payment of Claim ☐ Other _____

This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by me in writing. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires within one year of the signing of this form, or (specify date/event)_____. I understand that I am under no obligation to sign this form and that the person and/or agency listed above whom 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. The consent will last no longer than reasonably necessary to serve the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization. A copy of this consent has the same force and effect as the original. By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes**. I AM ALSO CONFIRMING THAT I HAVE READ AND UNDERSTAND THE RIGHTS WITH RESPECT TO THIS AUTHORIZATION, WHICH ARE LOCATED AT THE BOTTOM OF THIS AUTHORIZATION FORM.**

Signature of Client: _____ Date: _____
(Required for age 12 & over for AODA, 14 & over for Mental Health)

Signature of Legal Guardian: _____ Relationship: _____ Date: _____

ADDITIONAL INFORMATION REGARDING THE USE & DISCLOSURE OF YOUR HEALTH/CONFIDENTIAL INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

• **Right to Inspect or Copy the Confidential Information to be Used or Disclosed:** I understand that I have the right to inspect or copy the health or confidential information I have authorized to be used or disclosed by this authorization form to the extent required by DHS 92.05 and 92.06 of the Wisconsin Administrative Code. I may arrange to inspect my health or confidential information or obtain copies of my confidential information by contacting Winding Rivers Counseling LLC.

• **Copies:** I understand that I may be charged a reasonable fee for record copies.

• **Right to Receive a Copy of this Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I have the right to 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 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.

• **Right to Revoke this Authorization**: I understand that I can cancel this authorization at any time by providing a written notification to the Privacy Officer at Winding Rivers Counseling LLC or to my therapist in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization before receipt of the written notice of revocation; or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage.

• **Re-disclosure Notice:** I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health or confidential information.

• **I understand that a copy of this authorization will be considered valid as the original.**

• **Restrictions:** These restrictions on disclosure do not apply to communications of information between or among Winding Rivers Counseling, LLC personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.

•**AODA** I understand that my Substance Use Disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 , and Health Insurance Portability and Accountability act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.