Paulette Sears Counseling, LLC
927A S. 8th Street, Suite 300
Manitowoc, WI 54220
920-682-4804 www.paulettesearscounseling.com FAX 920-684-1110

Authorization for Release of Information

I, __________________________________, whose date of birth is _________________________, authorize ____, to disclose my mental health information to and/or obtain from:

Name ____
Address ____
City, State, Zip ____

Description of Information to be Disclosed
(Client/Parent should initial each item to be disclosed.)

___ Assessment
___ Diagnosis
___ Psychosocial Evaluation
___ Psychological Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Testing Information
___ Educational Information
___ Presence/Participation in Treatment
___ Continuing Care Plan
___ Treatment Progress
___ Other __________________________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: ____
____

Revocation

I understand I have a right to revoke this authorization, in writing, at any time, by sending written notification to Paulette Sears Counseling, LLC, at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on _________________________, or as otherwise indicated: ____

Forms of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, Paulette Sears Counseling, LLC, reserves the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

____ _________________________

Signature of Client Date

____ _________________________

Signature of Parent, Guardian or Personal Representative Date