Shorehaven Behavioral Health, Inc.

CLIENT AUTHORIZATION
for Disclosure of Confidential Information/Records

Complete a separate copy of this form for each person or institution which has records on you or to whom we should speak.

I, _____, consent to the disclosure of the specific information listed below, by written, faxed, electronic, or verbal communication,

regarding patient _____, born ____/____/___,

by/to Shorehaven Behavioral Health, Inc., 3900 W. Brown Deer, Suite 200, Brown Deer, WI 53209,
Ph: (414) 540-2170 Fax: (414) 540-2171

by/to _____

Purpose: The purpose or need for this disclosure is to help me(us) by:
( ) Treatment: Aiding in diagnosis and treatment planning

( ) Other Health Care Operations: Medical, educational, legal,
( ) Payment: Insurance and/or billing legal, or vocational planning, communications, or services
( ) Continuity of care with your previous providers

( ) Other Information:_____

I understand I may request a Shorehaven privacy policies notice. I understand I may restrict the information to be released and its use. I am aware of the information to be released and agree to its disclosure. I authorize the disclosure of the following specific information:
( ) Dates of service, treatment, hospitalization

( ) Psychiatric, social, psychological, & allied health evaluations
( ) Reports of progress & treatment

( ) Medical history, current medical conditions, medications
( ) School reports, evaluations, & observations

( ) BMCW Case Plan

( ) Diagnosis, prognosis, & treatment for physical and/or emotional disorders, including alcohol or drug abuse
( ) Court-ordered psychiatric or psychological evaluations, Protective services reports and studies

( ) Other:_____

Revocation: This consent may be revoked by written notice at any time except to the extent the provider of information has already acted upon it. In any case, consent expires twelve (15) months from the date below, or earlier if noted here:___/___/__.
***Re-Release*:** This information may not be further disclosed by the recipient without my written permission below.
Fee for Copies: A uniform and reasonable fee may be charged for a copy of records, which fee may be reduced or waived in accordance with agency policy.

This authorization form is intended to be in conformance with Section 51.30(4)(d), Wisconsin Statues, and Sections HSS 92.03(3)(d), 92.05, and 92.06., Wisconsin Administrative codes, and sections 49.53, 51.30(2), and 146.82 Wisconsin Statutes, and 42 CFR Part 1 and 45 CFR Part 160 and 164, Federal Regulations.
Services. Services may not be denied or restricted due to the denial of authorization to release information except insofar as denial of this authorization may in the judgment of the clinic or clinician compromise the ability of the clinic to provide effective services or to bill for services.
A photocopy of this form is an acceptable substitute for the original.

PATIENT(S)

Signature(s):_____

Date Signed:____/____/_____

Person Authorized to Sign for Patient:_____

Relationship:_____

Witness:_____

Staff: HIPAA, 45 CFR Parts 160 and 164 requires documentation of the history of all releases in a format which could be given to the patient upon request. Document the release on a separate progress note page. (Rev 5/25/06)