SHOREHAVEN
BEHAVIORAL HEALTH, INC.

3900 West Brown Deer Road, Suite 200
Brown Deer, WI 53209
Phone: 414.540.2170 • Fax: 414.540.2171
www.shorehavenbhi.com

Authorization for Disclosure of Confidential Information

This authorization form is intended to be in conformance with Section 49.53, 51.30(2), 51.30(4](d), and 146.82 Wisconsin Statues, Sections DHS 35, 75, 92.03(3)(d), 92.05, and 92.06, Wisconsin Admin codes, and 42 CFR Part 1 and 45, CFR Part 160 and 164, and Federal Regulations. A fill-in version of form is at https://www.shorehavenbhi.com/2023pdfs/ROI_Authorization_SBH_2023.pdf

The person signing this form voluntarily consents to the disclosure of the specific information listed below, by written, faxed, electronic, or verbal communication, regarding patient named _____, date of birth _____
by/to _____

_____

and Shorehaven Behavioral Health, Inc., 3900 W. Brown Deer Rd., Suite 200, Brown Deer, Wl 53209, (414) 540-2170, fax (414) 540-2171, Attn _____

The purpose or need for this disclosure is for:
❑ Treatment
❑ Aiding in diagnosis and treatment planning, continuity of care with current or previous providers.
❑ Payment
❑ Insurance, billing, and/or fees.
❑ Healthcare/Other Services
❑ Medical, educational, or vocational planning, communications, services, disability claims, insurance applications, legal.

Information to Release: 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 for:
❑ All medical records
❑ Records within this range of dates:
❑ Most recent two years of chart/progress notes, diagnostics, treatment plans, labs, special tests, discharge summary
❑ Diagnosis, prognosis, reports of progress, including hospitalization, for physical and/or emotional disorders including alcohol or drug abuse
❑ Psychiatric, social, psychological, school reports, observations and health evaluations
❑ Court-ordered psychiatric or psychological evaluations, Protective Services Reports, Stipulations, and CHIPS petitions
❑ Other:

Exclusions: Exclude the following information from release: _____

Right/Fee to Copy: You have the right to inspect or have a copy of the materials disclosed and to receive a copy of this document. Uniform, reasonable fees may be charged for a copy of records. The fee may be reduced in accordance with agency policy. Inter-therapist records are not usually subject to fees.

Revocation: This consent may be revoked by written notice at any time to Shorehaven Behavioral Health, Inc., or to the releasing party except to the extent the provider of information has already acted upon it. Action taken on this authorization prior to the date of revocation is legal and binding. If this release has been sent to or executed by the other party, copy of revocation will be sent to the releasing facility. I may receive a copy of the revocation.

In any case, consent expires 15 months from the date below, or earlier if noted here: _____

Disclaimer to Accompany Disclosures:
For alcohol/drug patient treatment records, check here: ❑
For AODA records, when Shorehaven releases information on a client with a Substance Use Disorder, the following disclaimer applies: This information has been disclosed to or from records protected by Federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Re-Release: I understand the information released may be included in treatment notes of the recipient. Any documents released may not be re-released without permission.

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. Signer may request a copy of this completed document.

A photocopy of this form is an acceptable substitute for the original.

Client, if 14 or older: _____

Effective on Date Signed: _____

Parent or Legal Guardian if Client is a Minor: _____

Effective on Date Signed: _____