Therapy House

700 Villa Street – Racine, WI 53403

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____ Date of Birth:_____

I hereby request and authorize:_____

_____

_____

_____
(individual, if appropriate)

To disclose to/from: _____
(therapist name here)
700 Villa Street
Racine, WI 53403

The following information:
_____ Diagnosis
_____ Psychiatric and psychological evaluations
_____ Reports of progress and treatment
_____ Medications and hospitalizations
_____ School or employment related records

This information will be used for the following purpose(s):

_____ Treatment planning
_____ Ongoing diagnosis
_____ Social, vocational, employment or educational planning
_____ Other _____

I understand that my records may be protected under Wisconsin law (WI stat. 51.30), governing Confidentiality of Mental Health Records, and/or Federal law (42 CFR Part 2), governing Confidentiality of Alcohol and Drug Abuse records. These records cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I have the right to inspect and/or receive a copy of the material to be disclosed upon payment of reasonable charges for photocopy service. 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, will expire one year following the date of signature unless otherwise indicated.

_____
(Date, event, or condition upon which consent will expire)

Signature of Patient:_____ Date:_____

Signature of Guardian:_____ Witness:_____