KETTLE MORAINE COUNSELING

400 W River Drive
West Bend WI 53090

W62 N281 Washington Ave
Cedarburg WI 53012

7280 S 13th Street
Oak Creek WI 53154

1446 Horicon Street
Mayville WI 53050

700 Rayovac Drive Suite 320
Madison WI 53711

W177N9856 River Crest Dr.
Suite 112
Germantown WI 53022

P: 262.334.4340 F: 262.334.4341 www.kettlemorainecounseling.com

Authorization To Release Information

_____ _____ _____ _____

Print Name | Maiden Name | SS# | DOB

I hereby authorize Kettle Moraine Counseling Services: ( ) to release to ( ) to receive from

_____

(Name of agency program or individual)

At_____

(Address)

The items checked below from the medical record of the client named above.

To Release:	To Receive:
( ) Intake & Assessment findings	( ) Intake & Assessment findings
( ) Progress Notes	_____
( ) Discharge Summary	_____
( ) Treatment Plan	_____
( ) Summary of Treatment	_____
( ) Verbal Report	( ) Verbal Report
( ) Other_____	( ) Other_____

This information will be used for the purpose of_____ or ( ) at the request of the individual.

I understand that the treatment records may include my mental health information. I understand that my records are protected by law and cannot be disclosed without my consent. I understand that I am not required to authorize release of confidential information. I may revoke this consent, in writing, at any time, except for information that has already been sent. Information that is released is no longer protected by the privacy practices of Kettle Moraine Counseling Services. You have the right to see what healthcare information has been released. This release will be valid for ONE YEAR(max) from the date of signature, or specify a different length of time_____.

_____ _____ _____

Signature (if over 18) | Printed Name | Date

_____ _____ _____

Signature of parent or legal guardian | Printed Name | Date

( ) I hereby revoke the above authorization. _____ _____

Signature | Date

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