Kettle Moraine Counseling

400 W River Dr **W62N281 Washingotn Ave** **7071 South 13th St**
West Bend WI 53090 **Cedarburg WI 53012** **Oak Creek WI 53154**
Phone: 262.334.4340 Fax: 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:
( ) Intake & Assessment findings
( ) Progress Notes
( ) Discharge Summary
( ) Treatment Plan
( ) Summary of Treatment
( ) Verbal Report
( ) Other_____

To Receive:
( ) Intake & Assessment findings
_____
_____
_____
_____
( ) Verbal Report
( ) 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