

COMPASS COUNSELING WAUSAU, LLC

AUTHORIZATION OF DISCLOSURE/RELEASE OF INFORMATION

NAME _____ DOB _____

I hereby request and authorize: Compass Counseling Wausau, LLC

Wausau Office Weston Office Antigo Office Wisconsin Rapids Office
530 Grant St 3704 Weston Ave 836 S. Superior St, 2503 8th St S.
Wausau, WI 54403 Weston, WI 54476 Suite 109 Wisconsin Rapids, WI 54494
(715) 845-5493 (715) 298-6364 Antigo, WI 54449 (715) 712-1523
Fax (715) 848-5645 Fax (715) 298-6365 (715) 623-2787 Fax (715) 712-0781
Fax (715) 623-2919

To Disclose to Receive from Exchange with (Check one)

Name: _____

Address: _____

City/State/Zip: _____

The following specific information from my records: Dates of Treatment:
Type of Treatment: Mental Health Alcohol/Drug Other (Specify)

Description of Information to be Disclosed:
(Patient/Client should initial each item to be disclosed) Verbal Written E-mail
Assessment Summary Educational Information
Psychological Evaluation Discharge/Transfer Summary
Psychiatric Evaluation Continuing Care Plan
Treatment Plan or Summary Progress in Treatment
Current Treatment Update After Care Plan
Medication Management Information Case Notes
Presence/Participation in Treatment Other (Specify)

Purpose: The purpose of this disclosure of information is to coordinate care.
Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at Compass Counseling Wausau, Attention Privacy Officer, 3704 Weston Ave, Weston, WI, 54476. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Authorization of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (423CFR Part 2.35).
Conditions: I further understand that Compass Counseling Wausau will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I understand that I am entitled to a copy of this release and the information released.
Expiration: This authorization is effective for one (1) year from the date of signing or as specified by this condition stated: (no longer than one year):

Signature of Patient/Client Date Signature of Parent or Guardian Date
Check here if patient/client/guardian refuses to sign authorization

Signature of Staff Witness Date

This information has been disclosed to you from records protected by federal confidentiality rules (42CFR.Part2). The 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 who it pertains or as otherwise permitted by 42CFR.Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse consumer. (Copy effective as original).