

COMPASS COUNSELING WAUSAU, LLC

AUTHORIZATION OF DISCLOSURE/RELEASE OF INFORMATION

NAME _____

DOB _____

I hereby request and authorize: Compass Counseling Wausau, LLC

Wausau Office
530 Grant St
Wausau, WI 54403
(715) 845-5493
Fax (715) 848-5645

Weston Office
3704 Weston Ave
Weston, WI 54476
(715) 298-6364
Fax (715) 298-6365

Wisconsin Rapids Office
420 3rd Street South
Wisconsin Rapids, WI 54494
(715) 712-1523
Fax (715) 712-0781

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)
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.
Conditions: I further understand that Compass Counseling Wausau will not condition my treatment on whether I give authorization for the requested disclosure.
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.
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).