Dr. Stress & Associates LLC

5840 Arndt Road – Suite 3, Eau Claire, WI 54701
Phone: 715-833-7111 Fax: 715-833-0454

AUTHORIZATION TO RELEASE INFORMATION

I, ____, _____/_____/________ do hereby consent to
(Patient name) (Date of Birth)
and authorize Dr. Stress & Associates and/or their staff members to disclose to / receive from:

____

____

____

P:____________________ F:____________________

For the purpose of:

☐ Care Coordination and Continuing of Treatment
☐ Case Management
☐ Transfer of Care
☐ Second Opinion/Referral
☐ Billing, Collection or Payment of Claims
☐ Personal
☐ Verbal or phone communication
☐ Two-Way Verbal and Written
☐ Other ______________________________
☐ Other ______________________________

I understand that specific information to be disclosed includes the following, and I have the right to inspect and receive copies of the material to be disclosed if I so choose.

☐ Acknowledge my admission and diagnoses (verbally and/or in writing)
☐ Progress Report (written or verbal)
☐ Psychological Exam/History
☐ Psychiatric Evaluation
☐ Aftercare Plan
☐ Other (Please specify):____
☐ Verbal exchange of information to review status in treatment and/or for services
☐ Physical Exam/History
☐ Social History (Summary only)
☐ Discharge Summary

I also understand that this consent may be revoked at any time, and this consent will remain in force (check one):

☐ For one year from date of signature
☐ Until I cancel this authorization in writing
☐ Until ________________________, 20_____

This authorization for Release of Information has been fully explained to me and I understand the contents and purpose.

____ ________________________
Signature of Client Date

____ ________________________
Signature of Legal Guardian Date

____ ________________________
Signature of Witness Date

REDISCLOSURE NOTICE TO PATIENT: I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organizationi(s) re-disclose my health information.

DISCLOSURE NOTICE TO RECIPIENT OF MENTAL HEALTH, ALCOHOL AND/OR DRUG TREATMENT RECORDS: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- **Right to receive copy of this authorization –** I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- **Right to withdraw this authorization –** I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the office manager of Dr. Stress & Associates. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form.
- **Mental health treatment records –** I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.