



American Foundation of Counseling Services
130 E. Walnut Street
Green Bay, WI 54301
(920) 437-8256
(920) 437-1188

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ DOB: _____

I AUTHORIZE:	TO EXCHANGE WITH:
_____	_____
Individual or Organization	Individual or Organization
_____	_____
Address	Address
_____	_____
City/State/Zip	City/State/Zip
_____	_____
Phone	Phone
_____	_____
Fax	Fax
FOR THE PURPOSE OF:	

I.E., AT THE REQUEST OF THE CLIENT FOR HIS/HER OWN USE, CONTINUING CARE, CASE MANAGEMENT, AUTHORIZING CONTINUED TREATMENT, PAYMENT OF BENEFITS, ETC. THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS FOR THE FOLLOWING DATES:	
From: _____ to _____	
<input type="checkbox"/> AODA and/or Psychiatric Discharge Summary which may include HIV Information	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> AODA and/or Psychiatric Reports	<input type="checkbox"/> OT/RT Reports
<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> Physical Examinations
<input type="checkbox"/> Lab/X-ray Reports	<input type="checkbox"/> HIV Testing/AIDS Related Reports
<input type="checkbox"/> Social Worker/Case Manager Reports	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Dr. Progress Notes/Orders	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Consults	
<input type="checkbox"/> Miscellaneous Reports (please specify) _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No If necessary, I authorize the use of a facsimile (fax) machine in disclosing this information.	

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to my provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date:

If I fail to specify an expiration date, this authorization will expire in one year.

I understand that authorizing the disclosure of health information is voluntary and I need not sign this form in order to assure treatment. * I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal privacy standards. If I have questions about the disclosure of my health information, I can contact my case manager or physician at the address above.

_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian/Authorized Representative	Date
_____	_____
Witness Signature	Date

This confidential copy of the American Foundation of Counseling Services, Inc. case record may not be duplicated, copied, or disclosed without the informed consent of the individual to whom the information pertains.

*Provision of research-related treatment or treatment that is for the sole purpose of creating health information to a third party will not be provided without your written authorization.