



American Foundation of Counseling Services, Inc.
 130 E. Walnut St. Ste. 706
 Green Bay, WI 54301
 (920)437-8256

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____

DOB: _____

<p>I AUTHORIZE:</p> <p>_____</p> <p>Individual or Organization</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p>	<p>TO EXCHANGE PHI WITH:</p> <p>_____</p> <p>Individual or Organization</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p>
<p>FOR THE PURPOSE OF:</p> <p>_____</p> <p>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:</p> <p>From: _____ to: _____</p> <p><input type="checkbox"/> AODA and/or Psychiatric Discharge Summary which may include HIV information</p> <p><input type="checkbox"/> AODA and/or Psychiatric Reports</p> <p><input type="checkbox"/> Psychological Reports</p> <p><input type="checkbox"/> Lab/X-ray Reports</p> <p><input type="checkbox"/> Social Worker/Case Manager Reports</p> <p><input type="checkbox"/> Dr. Progress Notes/Order</p> <p><input type="checkbox"/> Consults</p> <p><input type="checkbox"/> Miscellaneous Reports (Please specify): _____</p> <p><input type="checkbox"/> Nurses Notes</p> <p><input type="checkbox"/> OT/RT Reports</p> <p><input type="checkbox"/> Physical Examinations</p> <p><input type="checkbox"/> HIV Testing Results/AIDS Related Reports</p> <p><input type="checkbox"/> Treatment Plan</p>	

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 this 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 an unauthorized redisclosure 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

 Relationship/ 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 for disclosure to a third party will not be provided without your written authorization.