Behavioral Health Clinic

IN PERSON • ONLINE

www.wibehavioralhealth.com

Behavioral Health Clinic
Phone: (855)-607-8242
Fax: (715)-848-0425
Email: appointments@bhclinic.com
Website: wibehavioralhealth.com

Today's Date: _____

Client's Name: _____

Client's Date of Birth: _____

Consent for Release of Confidential Information

I. I hereby authorize Behavioral Health Clinic, LLC to release and exchange confidential health information with the following person or organization as indicated below via telephone, fax, mail, or electronic upload for the patient named above. I specifically authorize the release and exchange of medical, mental health and/or substance use treatment records

The purpose of disclosure is continuity of care/care coordination.

Primary Care Provider Name	Primary Care Provider Address	Primary Care Provider Phone Number	Primary Care Provider Fax Number
_____	_____	_____	_____

Practice Name	Main Practice Address	Practice Phone Number	Practice Fax Number
Behavioral Health Clinic, LLC	630 S. 36th Ave. Wausau, WI 54401	(855) 607-8242	(715) 848-0425

The type of information to be used or disclosed is as follows (SELECT ALL THAT APPLY):

☐ ALL RECORDS ☐ Diagnostic Assessment Intake ☐ Treatment Notes ☐ Treatment Plan
☐ Testing Report ☐ Alcohol and Drug Abuse Treatment Information ☐ Appointment Information
☐ Billing Information ☐ Other ☐ NO RECORDS

Please describe "Other"

_____

This authorization ends:

◯ When revoked in writing ◯ One year from this form date ◯ Other

Please describe date when authorization ends if "Other":

_____

Any specific information that you do not want shared between providers?

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it if requested. A copy of this authorization is as valid as the original.

If the patient is a minor or unable to sign, please complete the following:

Name of Parent/Legal Guardian: _____

_____ _____

Client or Legal Guardian Signature Date