family service
counseling • support • compassion

Authorization to Release and/or Obtain Confidential Information

I, the undersigned, hereby authorize Family Service and _____
Name of Family Service Staff Person

101 W. Broadway, Waukesha, WI 53186 / Ph: 262-547-5567 / Fax: 262-547-1608

☐ to release to and/or ☐ obtain from (check one or both):

Note: *Separate release required for each individual to whom information may be obtained from or released to.*

_____ _____
Individual/Agency/Organization Phone Number

_____ _____
Street Address City, State, Zip Code

Confidential records and/or information as specified below concerning:

_____ _____
Name Birth Date

Confidential information to be released/obtained:

☐Intake/Initial Assessment & Progress Assessments
☐Psychiatric/Psychological Evaluations
☐Medications
☐Treatment Plan and/or Treatment Summary
☐Treatment Progress Assessments and Updates
☐Forensic Interview/DVDs and related staff assessments
☐Referrals Made
☐ Progress Notes
☐Behavioral, Emotional, and Academic Needs of Client
☐Medical Evaluations/H&P Records
☐Other (specify) __Click or tap here to enter text._____

Format of information to be released: ☐ Written and ☐ Verbal

Purpose for need of disclosure:

☐Continuity and Coordination of Care
☐Medical Care
☐Legal Investigation or Action
☐ Advocate for child's behavioral, emotional, and academic success
☐ Verify Participation in Treatment
☐Other (specify) _____

Your rights with respect to this authorization:

I understand that I have the right to inspect or have a copy of the confidential information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, which I am not required to do; I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact Family Service staff providing/coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person and or agency listed above have already made in reference to this authorization.

(I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further redisclosure without obtaining my authorization.)

Expiration date: This authorization is good until the completion of active services with Family Service unless a specific date is entered here or unless a written notice of revocation is submitted. Expiration date: _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of the authorization will be considered as valid as the original.

Print Name: _____

Signature: _____ Date: _____

☐ Client ☐ Parent of Minor ☐ Legal Guardian ☐Client's Representative

☐ By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.

Witness: _____