MW COUNSELING

Authorization for Release of Confidential Information

Patient Information:

Name:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

I hereby authorize and request: Melissa Walden, MS, LPC of MW Counseling, LLC

- ☐ To Release Information To:
- ☐ To Obtain Information From:

Person/Organization: _____

Address:_____City, State, Zip:_____

Phone:_____ Fax:_____

- ☐ Records Authorized for Release
- ☐ Psychiatric Reports/Consults
- ☐ Psychotherapy Progress Notes
- ☐ Admission/Discharge Summaries
- ☐ Hospital Records
- ☐ Other
- ☐ Psychotherapy Tests/Evaluations
- ☐ After Care Plan
- ☐ Telephone/Face to Face Communications
- ☐ Treatment Plans
- ☐ Social History
- ☐ School Functioning/IEP or testing results

Purpose of this exchange is to:

- ☐ Coordinate Care
- ☐ Other

This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period, please check one of the boxes below. Note: If you specific an additional time period, this authorization will apply to your medical information generated during the additional time period.

- ☐ Other Specific expiration date:_____
- ☐ Other specific expiration event (specify): 12 months from the date signed_____

PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults on mental illness, and developmental disabilities, alcohol and/or drug treatment, AIDS or AIDS related illness and/or HIV test results, with the following exceptions:

Signature of Patient:_____ Date:_____

Legally Authorized Persons Signature:_____Date:_____

Patient is: Minor Incompetence/Incapacitated Deceased

Legal Authority:

Legal Guardian Parent of Minor Spouse of Deceased Health Care Agent Personal Representative of Deceased

Witness:_____Date:_____

1050 Regent Street Madison WI 608-843-7055 melissa@mwcounseling.com

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MW Counseling, LLC, honors a client's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign: You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, MW Counseling, LLC, may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstance where the insurer is contesting a claim. Your revocation must be in writing and addressed to: MW Counseling, LLC, 1050 Regent Street, Madison, WI 53715.

Re-release: If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect: You have the right to inspect, or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the clinician at: MW Counseling, LLC, from whom you receive care.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact your clinician/therapist at: MW Counseling, LLC .