IntegrityCounseling
Finding Your True Self

Consent for Release of Information (ROI)

I hereby authorize Integrity Counseling, LLC the right to use and disclose of my individual identifiable health information described below. I understand that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I understand that I am under no obligation to sign this form and that Integrity Counseling may or may not disclose my condition, treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I understand that I have the right to revoke this authorization, but that I must do so in writing. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

I,_____do hereby consent to and authorization:

Integrity Counseling, LLC
1011 N Lynndale Dr Suite 2D
Appleton, WI 54914
Office: 920-385-1420
FAX: 866-327-3295
Mailing Address:
P.O. Box 282, Black Creek, WI 54106

Attn:_____
Phone:_____

Please Check One: ☐release to ☐obtain from ☐mutual release

Name:_____

_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____

information of health and treatment records of_____, DOB: _____

relating to diagnosis, prognosis, or treatment during my treatment of the following dates:_____.

I understand the specific types of disclosure will include:

The Following written and verbal information:
- ☐ evaluation
- ☐ summary of services
- ☐ discharge summary
- ☐ progress notes
- ☐ psychological, psychiatric evaluation/diagnosis
- ☐ medical records
- ☐ other: _____

Purpose for this disclosure:
- ☐ assessment
- ☐ consultation
- ☐ coordination of care
- ☐ continued care
- ☐ diagnosis and treatment planning
- ☐ other: _____

Expiration date: This authorization is good until the following date(s)_____or for one year from the date signed.

_____ _____
(client) *(14 years and older, PLEASE sign)* (date)

_____ _____
(parent/legal guardian) (date)

_____ _____
(therapist) (date)