Integrity Counseling

Locations: 404 N Main St, Ste 612 Oshkosh, WI 54901 | 1011 N Lynndale Dr. Ste 2D Appleton, WI 54914 | 225 S Main St, Ste 3 Seymour, WI 54165

PHONE: 920-385-1420 **FAX:** 866-327-3295

Mailing Address: P.O. Box 282, Black Creek, WI 54106

Consent for Release of Information (ROI)

Patient Name: _____ DOB: _____

Authorizes: (Information to be released from)

_____
Name

_____
Address

_____
Phone Number

_____
Fax Number

Information released to:

_____
Name

_____
Address

_____
Phone Number

_____
Fax Number

Two-way communication permissible? □ Yes □ No

THE FOLLOWING WRITTEN OR VERBAL INFORMATION FOR THE FOLLOWING DATES:

From: _____ To: _____

Information to be released: (Check all that apply)

□ Diagnosis, assessment, treatment planning
□ Consultation
□ Coordination of care
□ Continued care
□ Legal purposes
□ Insurance/Work Comp
□ Other: (please specify) _____

The following specific written or verbal information is being requested, including information created after the date of signature but before the expiration (Please "X" each line applying to request):

□ Initial Evaluation
□ Progress Notes
□ Medical Records/Medications
□ Summary of services
□ Discharge Summary
□ Treatment Plan/Goals
□ Payments/Billing
□ Psychological, Psychiatric Evaluation/Diagnosis
□ Scheduling
□ AODA Assessments & Discharge Plan
□ Other (please specify): _____

Expiration Date: This authorization is good until this date:_____ **OR** for one (1) year from the date signed.

I hereby authorize Integrity Counseling LLC the right to use and disclose my individual identifiable health information described above. 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 LLC 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.

_____ _____ _____
Print Patient Name | Patient Signature (14 years and older) | Date

_____ _____ _____
Print Parent/Legal Guardian Name | Parent/Legal Guardian Signature | Date

_____ _____ _____
Print Therapist | Therapist Signature | Date