Authorization for Release of Information

(this form is required for certain information to be shared between providers and says you agree to it)

I, _____whose Date of Birth is _____,

Authorize **Catherine C. Olson Counseling, MSW, LCSW, 651-269-0924, P.O. 253 Hammond, WI, 54015, c.olsoncounseling@gmail.com,**

to disclose to and/or obtain from (name of agency or person):
_____

the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____Current Treatment Update
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____Continuing Care Plan
_____Progress in Treatment
_____ Discharge/Transfer Summary
____Medication Management Information
____Presence Participation in Treatment
____Nursing/Medical Information
____Academic Information
____VERBAL CONSULTATION
____Other

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify: _____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Catherine C. Olson at P.O. 253, 815 Davis Street, Hammond, WI 54015, 651-269-0924. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:_____

Conditions
I further understand that Catherine C. Olson will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Upon my request, I will be given a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date

_____Check here if patient/client refuses to sign authorization

_____
Signature of Staff Witness Date

Document from National Assn. of Social Workers