Shore Counseling and Consulting Clinic

AUTHORIZATION / RELEASE OF INFORMATION

To Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Client Name (print):________________________ Date of Birth: _____________

I authorize _____________________________ (person/agency) to use or disclose the following information:

INFORMATION TYPE	AUTHORIZED:	DISCLOSED:
Outpatient Clinical Records	▢	▢
Discharge Summary	▢	▢
Psychological or Psychiatric Evaluation Reports	▢	▢
Summary of Medical History	▢	▢
Billing Records	▢	▢
Medication History	▢	▢
Communicate Clinical Information Verbally to Each Other	▢	▢
Other: ____	▢	▢

To: ____ (person/agency)

For service/treatment dates: ____

The information will be used for the following purposes:

____

____

I understand and agree that, unless withdrawn, this authorization will expire *1 year* from date of signature below:

____ ___________________________

Signature of client or personal representative Date

____ ___________________________

Printed name of client or representative Relationship to the Client

Please Return To: **Shore Counseling and Consulting Clinic**
2600 N. Mayfair Rd., Suite 650, Wauwatosa, WI 53226
Fax: (414) 771-9543