Name of Contracted Independent Provider: _____

WETZEL-RASMUSSEN COUNSELING SERVICES
N11230 Antigo Street, P.O. Box 278
Elcho, WI 54428
(715) 275-3934
Fax: (715) 275–4510

Consent for Release of Information
To Other Persons and/or From Other Persons

Client Name: _____ **Date of Birth:** _____

Name of Person: _____

Agency: _____

Address: _____

_____

_____

Phone Number: _____

I give my consent for Wetzel-Rasmussen Counseling Services to disclose, receive and exchange the following information with other persons:

__ Date/Time of Appointments
__ Case Notes
__ Evaluations
__ Recommendations
__ Treatment Plan
__ Psychological Tests/Screeners

Other information to be shared: _____
Records from the following time period: _____
For the purpose of: _____

I understand that I have the right to inspect and receive a copy of this document and the material to be disclosed as required under ss, HFS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this authorization in writing at any time except to the extent that information already release pursuant to this consent cannot be recalled. [45 CFR 164.508(c)(2)(i)] Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment. (42 CFR Part 2.35). This consent will be existent for one year from the date of the signing. It may be terminated or extended at the request of the client.

Client Name: _____ **Parent/Guardian:** _____

Signature: _____ **Signature:** _____

Date: _____ **Date:** _____

Wetzel-Rasmussen Counseling Services

REDISCLOSURE NOTICE TO PATIENT:
I understand that if the person(s) and/or organizations(s) listed are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose my health information.
DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS:
Unless otherwise authorized by Section 146.32 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written consent of the person who is the subject of such records.
DISCLOSURE NOTICE TO RECIPIENT OF MENTAL HEALTH, ALCHHOL AND/OR DRUG TREATMENT RECORDS:
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to receive copy of this authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization.**
- **Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed above may not condition treatment, payment, enrollment in a health care benefits on my decision to sign this authorization except regarding:**
  - **Research-related treatment**
  - **Health plan enrollment or eligibility**
  - **The provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party**
- **Right to withdraw this authorization – I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Health Information Management (medical records) department. I understand that any cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.**
- **Right to inspect a copy of the health information to be used or disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Management (medical records) department.**
- **Mental Health treatment records - I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.06 of the Wisconsin Administrative Code**

CLIENT INITIALS _____