Name of Contracted Independent Provider: _____

WETZEL-RASMUSSEN COUNSELING SERVICES
N11230 Antigo Street PO Box 278
Elcho WI 54428-0278
(715)275-3934
Fax: (715) 275–4510

Consent For Release of Information
To Insurance Company

Client Name:_____ Date of Birth: _____

Name of Insurance Company: _____

Address: _____

_____

_____

Phone Number: _____

I give my consent for Wetzel-Rasmussen Counseling Service to exchange the following information with my insurance company verbally and/or in writing:

_x Treatment Records
_x Case Notes
_x Evaluations
_x Recommendations
_x Treatment Plan
_x Psychological Tests

Other information to be shared: _____
For the purpose of: Collaboration and payment

Client Name: _____ **Guardian Name: _____**
Signature: _____ **Signature: _____**
Date: _____ **Date: _____**

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.