

Arbor Mental Health Center AUTHORIZATION OF DISCLOSURE/RELEASE OF INFORMATION

NAME		DOB			
I hereby request and authors Disclose		l Health Center,		Check one)	
Name:					
Address:					
G': /G: . /G'					
The following specific information from my rec Type of Treatment: Mental Health		ement:			
Description of Information to be Displaced	V11	W/-:44	E	F	
<u>Description of Information to be Disclosed:</u> Assessment Summary		Written _ ducational Inform		Fax	
Psychological Evaluation		ischarge/Transfer			
Psychiatric Evaluation	C	ontinuing Care Pl	an		
Treatment Plan or Summary	Pr	rogress in Treatmo	ent		
Current Treatment Update	A	fter Care Plan			
Medication Management Information		ase Notes			
Presence/Participation in Treatment		Other (Specify) _			
Purpose: The purpose of this disclosure of informat Revocation: I understand that I have a right to revok to the Chief of Operations at Arbor Mental Health revocation of the authorization is not effective to Authorization of disclosure to Criminal Justice Age effective termination or revocation of my release fr was mandated into treatment (423CFR Part 2.35). Conditions: I further understand that Arbor Mental authorization for the requested disclosure. However have the following consequences: information will refer to the conditions of the requested disclosure.	ce this authorization, in Center 500 N. 3 rd St. St. the extent that action encies will remain in efform confinement, probate the tenter will not r, it has been explained	writing, at any time ste. 220, Wausau, V has been taken in fect and cannot be ration or parole or o condition my treatn to me that failure to	VI. I further user reliance on the revoked by ment their proceeding ment on whether program this autho	nderstand that a e authorization. until formal and s under which I give rization may	
Form of Disclosure: Unless you have specifically reserve the right to disclose information as permitte consistent with applicable law, including, but not lin Redisclosure: I understand that there is the potentia authorization may be redisclosed by the recipient and privacy regulations, unless a State law applies that is I understand that I am entitled to a copy of this relea Expiration: This authorization is effective for one (I longer than one year):	d by this authorization nited to, verbally, in paid that the protected he the protected health into some strict than HIPA use and the information	in any manner that per format or electro- ealth information the formation will no los A and provides add released.	we deem to be onically. nat is disclosed nger be protecte litional privacy	appropriate and pursuant to this d by the HIPAA protections.	
Signature of Patient/Client Dat Check here if patient/client/guardian refuses to	_	re of Parent or Gu	ardian	Date	
Signature of Staff Witness			Date		

This information has been disclosed to you from records protected by federal confidentiality rules (42CFR.Part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42CFR.Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse consumer. (Copy effective as original).