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**Authorization for Release of Information**

630 Cherry Street, Green Bay, Wisconsin 54301

Phone: 920-435-2093 Fax: 920-435-2580

 [www.jackienitschkecenter.com](http://www.jackienitschkecenter.com)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section I – Patient Information**

|  |
| --- |
| Name:  |
| Street Address:  | Birth Date:  |
| City:  | State:  | Zip:  |
| Phone Number:  |

I, or my authorized representative, hereby authorize Jackie Nitschke Center and their respective employees to disclose and/or obtain my Personal Health Information (PHI) and Insurance Record to the designee identified below.

**Please Check One: \_\_\_\_\_Disclose To \_\_\_\_\_Obtain From \_\_X\_\_\_ Two-Way Release with**

**Section II – Authorized Designee (to whom the information will be sent to/obtained from)**

|  |  |
| --- | --- |
| Agency:  | Contact:  |
| Street Address:  |
| City:  | State:  | Zip:  |
| Phone:  | Fax:  |

**Section III – Specific Information to be released:**

\_\_\_AODA Assessment \_\_\_Progress Notes

\_\_\_Discharge Summary\_\_\_Legal Information

\_\_Client Status \_\_\_Medical Information

\_\_\_Treatment Plan and Review \_\_\_ Other (specify below)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the Purpose of:**

\_\_\_Continuation of AODA \_\_\_Treatment planning

\_\_\_Further mental health evaluation, treatment, or care \_\_\_Research

\_\_\_Other:

Please release the above information from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:**

* I hereby authorize the use and disclosure of my individually identifiable information as described below.
* I understand that signing this information is voluntary; my treatment, payment, enrollment, or eligibility benefits will not be conditioned upon my authorization of disclosure.
* I understand that I am entitled to receive a copy of this form upon signing it and that I have the right to inspect and/or receive a copy of the information to be disclosed on this form as required under ss. HFS 92.05 and 92.06.
* I understand that any disclosure of information carries with it the potential for unauthorized redisclosure.
* I understand this information has been disclosed to the named person/organization from records whose confidentiality is protected under Federal Law. Federal regulations prohibit the named person/organization from making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.
* I understand that I have a right to revoke this authorization, but that I must do so in writing to the Executive Director. I also understand that the revocation applies to uses and disclosures made after the revocation is made. If not previously revoked, this consent will terminate within nine months of the dated signature or on the date specified.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Signature Date

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE USED AS VALID AS THE ORIGINAL

Date Mailed\_\_\_\_\_\_\_\_\_\_\_\_ Date Faxed\_\_\_\_\_\_\_\_\_\_\_\_\_\_