AUTHORIZATION FOR DISCLOSURE OF CONFINDENTIAL INFORMATION

PLEASE PRINT

PATIENT NAME: ____ DOB: ____________________

I authorize Dr. Neil Fullan and Anima Behavioral Health to exchange information with the following party or parties: ***Please Include phone and fax numbers and address.***

____
(Name of person or organization, phone number and address)

____
(Name of person or organization, phone number and address)

____
(Name of person or organization, phone number and address)

Purpose of Exchange of Information

By signing this release, I give my consent to the above provider to exchange information, either verbal or written, via mail or electronic media to the party or parties listed above. I understand that this may include the release of information pertaining to psychiatric evaluations, progress and session notes, consultations, and any other information related to my ongoing treatment. I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information may be re-disclosed without my authorization.

I understand that I have the right to inspect and receive a copy of the disclosed material and a copy of this consent form as established in this agency's policies and procedures. This authorization to release information may be revoked by me at any time, in writing, except to the extent that action has been taken in reliance therein. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not reproduced by federal privacy standards.

This authorization will remain in effect until revoked ____________________________.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent/Guardian Date

____ ____________________
Signature of Witness Date

NOTE TO CLIENT AND RECIPIENT OF INFORMATION: This information has been disclosed to the above named person/organization from records whose confidentiality is protected by WI Statute 51.30, HFS 75.13 and/or Federal Regulation 42 CFR, Part II. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Dr. Neil Fullan
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