

# CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: Sabrina Santa Clara, BA, RYT, CMT PO Box 270669, Louisville CO 80027

To release information to     To obtain information from

*(Check one box or both. By checking both, you are authorized an exchange of information between the agencies/individuals listed)*

Agency/Individual \_\_\_\_\_

Individual: \_\_\_\_\_

Street: \_\_\_\_\_

Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

From the records of:

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Purpose or need for disclosure is to assist in the preparation of: (check all that apply)

Coordination of Services     Continued Treatment

Legal Matters     Other (specify) \_\_\_\_\_

Type of information to be disclosed: (check all that apply)

Mental Health     Medical     Alcohol & Other Drug

Legal Records     HIV     Other (specify) \_\_\_\_\_

Specific information to be disclosed: *(check all that apply)*

Progress Reports     Intake Summary     Assessments + Diagnoses

Case Notes     MVD Status Reports     Treatment Goals & Plans

Clinical Impressions     Personal Knowledge Other (specify) \_\_\_\_\_

I understand that:

- a) My records are protected under State and Federal regulations governing confidentiality
  - Mental Health – Sec. 51.30, Wisc. States.; & HRS 92, Wis. Admin. Code
  - Alcohol & Other Drug Abuse – 42 CFR, Part 2; Sec. 51.0, Wis. Stats; & HFS 92, Wis. Admin Code
  - Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, pts 160 & 164
- b) I will receive a copy of this form and have the right to inspect and receive a copy of the material to be disclosed, and that information received cannot be disclosed further without my written consent unless otherwise provided for in the regulations
- c) I may revoke this consent at any time by giving written notice to Sabrina Santa Clara, except to the extent that information has already been disclosed based on this release
- d) Generally I am not required to sign this form in order to receive services with Sabrina Santa Clara, however, there are certain circumstances permitted under applicable law where treatment may be denied unless there is a signed release.

This consent (unless expressly revoked earlier) expires on: \_\_\_\_\_

*(Date, event or condition upon which expiration occurs – not to exceed one year from date of signature below.)*

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Other Person Authorized to Consent (where applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date