COLLABORATIVE COUNSELING, LLC
CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ Birth Date: _____ Phone: _____

_____
Address City, State, Zip

Authorizes:
Collaborative Counseling LLC

Circle Location: 12918 63rd Ave N, Maple Grove, MN 55369 – 901 4th St, Hudson, WI 54016 – 1740 Brackett Ave, Eau Claire, WI 54701
8500 210th St W, Lakeville, MN 55044 – 403 Stageline Rd, Hudson, WI 54016

To: ☐ Release to: ☐ Receive from: ☐ Verbally exchange with:

☐ All my treating providers from _____

☐ All my non-treating providers from _____

_____ _____
Name of Organization/Individual Address City, State Zip

_____
Telephone Fax

In compliance with WI and MN Statutes and federal regulations which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health ☐ Substance Use Disorder ☐ HIV ☐ Juvenile Supervision
☐ Sexually Transmitted Disease ☐ Developmental Disabilities ☐Physical Disabilities ☐Child Protection Services
☐Other (specify)_____

Information to be released: (check all that apply)

☐ Discharge and Closing Summaries ☐ Chemical History/Assessment ☐ CPS Reports
☐ Prescription for Treatment ☐ Admission History and Evaluations/Assessments ☐ Social History
☐ Progress Reports/Case Notes ☐ Treatment Plans/Agreements ☐ Lab Reports
☐ Psychiatric Evaluations (include diagnosis/prognosis) ☐ Contracted Agency Discharge/assessment ☐ Aftercare Plans
☐ Medical Reports/Physical Exams ☐ Court Reports/Custody Studies ☐Vocational Eval Reports
☐ Therapy Progress Reports ☐Psychological Tests/Evaluations ☐School Records
☐Speech ☐ OT ☐ PT
☐Other(specify)_____

For the following dates: From _____ to _____

The specific purpose or need for such disclosure is: (check all that apply)
☐ Coordination of Care ☐ Obtain History ☐ Human Services investigation ☐ Other (specify) _____

This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by me in writing. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires within one year of the signing of this form, or (specify date/event) _____. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. The consent will last no longer than reasonably necessary to serve the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization. A copy of this consent has the same force and effect as the original. By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes. **I AM ALSO CONFIRMING THAT I HAVE READ AND UNDERSTAND THE RIGHTS WITH RESPECT TO THIS AUTHORIZATION, WHICH ARE LOCATED ON THE BACK OF THIS AUTHORIZATION FORM.**

Signature of Client: _____ Date: _____

Signature of Guardian/Legal Rep: _____ Date: _____

If signed by a person other than the patient, complete the following:

1. Client is: ☐ Minor ☐ Incompetent ☐ Unable to sign due to disability ☐ Deceased
2. Legal Authority: ☐ Parent of Minor ☐ Legal Guardian/Representative

** All persons signing for the release of records instead of the client must state their relationship to the client and have proof of legal authority attached to this authorization before we will release any records. (i.e. Guardianship Papers)**

Signature of Witness: _____ Date: _____
(To be signed only if patient cannot sign authorization)

ADDITIONAL INFORMATION REGARDING THE USE & DISCLOSURE OF YOUR HEALTH/CONFIDENTIAL INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Inspect or Copy the Confidential Information to be Used or Disclosed:** I understand that I have the right to inspect or copy the health of confidential information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health or confidential information or obtain copies of my confidential information by contacting my therapist at Collaborative Counseling LLC or the admin support team.
- **I understand that I may be charged a fee for record copies.**
- **Right to Receive a Copy of this Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Revoke this Authorization:** I understand that I can cancel this authorization at any time by providing a written notification to the Privacy Officer at Collaborative Counseling LLC or to my therapist in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization before receipt of the written notice of revocation; or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage.
- **Re-disclosure Notice:** I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health or confidential information.
- **I understand that a copy of this authorization will be considered valid as the original.**
- **These restrictions** on disclosure do not apply to communications of information between or among Collaborative Counseling LLC personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.
- **I understand** that my Substance Use Disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 , and Health Insurance Portability and Accountability act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Updated May 2018