Christian Life Counseling LLC
Eastbrook Office Park
12630 W. North Avenue
Brookfield, WI 53005
262-785-1008
Fax 262-432-9059

Authorization for Release of Confidential Information

The purpose of this document is to convey my signed consent so that the named individual/organization may disclose/receive/exchange information to the individual/agency listed below.

Patient Name_________________________________ **Date of Birth**_______________________________

I authorize and give permission for: _____ To exchange information _____ to disclose to (recipient):

____ Christian Life Counseling Center	_____ Christian Life Counseling
____ Organization/individual	_____ Organization/individual
Name, Address, Phone and Fax Numbers:	**Name, Address, Phone and Fax numbers:**
____________________________________	______________________________________
____________________________________	______________________________________
____________________________________	______________________________________
____________________________________	______________________________________

The purpose for releasing/obtaining these records is:___ To aid in the continuity of care or (Specify):_______________
The specific and relevant information to be released, obtained or exchanged_______________________________
____

_____Assessments/Evaluations _____Progress Notes
_____Discharge Summary _____Treatment Plans
_____Other _____Verbal Communication

Dates of Service Authorized to Release: All____ I authorize only the following dates:_________________________
_____By checking this box I am authorizing verbal communication only, no records will be released.
_____I understand that the information in my health record may include information relating to mental health, alcohol and/or drug abuse.

This authorization is **voluntary**. CLC will not condition your treatment on this authorization. I understand that I have a right to **revoke** this authorization at any time. I can do so by submitting my revocation in writing to CLC. I understand that my revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by the confidentiality rules. If I have questions about the disclosure of my health information, I can contact Christian Life Counseling at 262-785-1008 and/or above address.

I have read the above information and understand and agree to the nature of this release.

Expiration Date: This authorization is valid until the following date/condition or one year from date signed

___________________________________	___________________________________
Signature of Patient	Date
___________________________________	___________________________________
Signature of personal representative	Relationship/legal authority