



Consent for Release of Information (ROI)

Patient Name: _____ DOB: _____

Authorizes: (Information to be released from)

Information released to:

Name

Name

Address:
100 N Main St, 1011 N Lynndale Dr.
Ste 103 Ste 2D
Oshkosh, WI 54901 Appleton, WI 54914

Address

Phone Number

Phone Number

866-327-3295

Fax Number

Fax Number

Two-way communication permissible? Yes No

THE FOLLOWING WRITTEN OR VERBAL INFORMATION FOR THE FOLLOWING DATES:

From: _____ To: _____

Purpose for release: (Check all that apply)

- Diagnosis, assessment, treatment planning
- Consultation
- Coordination of care
- Continued care
- Legal purposes
- Insurance/Work Comp
- Other: (please specify) _____

The following specific written or verbal information is being requested, including information created after the date of signature but before the expiration (Please "X" each line applying to request):

- Initial Evaluation
- Progress Notes
- Medical Records/Medications
- Summary of services
- Discharge Summary
- Treatment Plan/Goals
- Payments/Billing
- Psychological, Psychiatric Evaluation/Diagnosis
- Scheduling
- AODA Assessments & Discharge Plan
- Other (please specify): _____

Expiration Date: This authorization is good until this date: _____ **OR** for one (1) year from the date signed.

I hereby authorize Integrity Counseling LLC the right to use and disclose my individual identifiable health information described above. I understand that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I understand that I am under no obligation to sign this form and that Integrity Counseling LLC may or may not disclose my condition, treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I understand that I have the right to revoke this authorization, but that I must do so in writing. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Print Patient Name Patient Signature (14 years and older) Date

Print Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

Print Therapist Therapist Signature Date