Eclipse Counseling LLC
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ECLIPSE counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Client Legal Name ____ Date of Birth _________________

Client Former Name (if any) _________________________________ Phone Number _______________________

Client Address ____
Number Street City State Zip

RECIPIENT AUTHORIZATION

I, ______________________________________, authorize Eclipse Counseling LLC to disclose to and/or obtain from:
[Insert Legal Name of Client or Representative]

Name of Person, Facility, or Organization ____

Address ____
Number Street City State Zip

Phone Number _____________________ Fax Number ______________________

INFORMATION TO BE RELEASED (State and federal regulations require special permission to release otherwise privileged information)

Use the letters in the key below for each item that you want disclosed:

Key: **V** – Verbal **W** – Written **R** – Release To **O** – Obtain From **E** - Exchange Both Ways

_______ Intake/Progress Notes
_______ Discharge/Transfer Summary
_______ Treatment Plan or Summary
_______ Medical Records
_______ Psychiatric Treatment Records
_______ School Records
_______ Child Protective Services Records
_______ Court and/or Law Enforcement Records
_______ Psychological Evaluation
_______ Psychiatric Evaluation
_______ Psychosexual Evaluation
_______ Other Evaluation _________________________
_______ Alcohol & Substance Abuse Records (specify) _________________________
_______ Schedule Appointments
_______ Progress in Treatment
_______ Presence/Participation in Treatment
_______ Current Treatment Goals
_______ Medication Management Information
_______ Diagnosis
_______ Demographic Information
_______ Educational Information
_______ Other_______________________________

For the following dates: From __________________ to ___________________ OR ☐ All

PURPOSE OR NEED FOR THIS DISCLOSURE (check all that are applicable)

☐ Coordination of Care
☐ Human Services Investigation
☐ At Request of Individual
☐ Insurance Eligibility/Benefits
☐ Legal Investigation or Action
☐ Other (specify) ___________________________

EXPIRATION DATE OF THIS AUTHORIZATON

If not previously revoked, this consent will terminate: ☐ after (specify date/event) ________________ or ☐ in one year.

If custodial parent, have you ever been denied physical placement of the above minor? ☐ Yes ☐ No ☐ N/A

Do you have legal custody of the minor listed above? ☐ Yes ☐ No ☐ N/A

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

Signature of Client ____ Date ____________________

Signature of Guardian/Legal Rep _________________________________ Print Name ____________________ 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: ☐ Custodial Parent ☐ 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 Eclipse Counseling LLC.
- **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 Eclipse 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 Eclipse 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.
- **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. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Note to the recipient of information: This disclosed information is protected under Federal Law titled Standards for Privacy of Individually Identifiable Health Information 42 C.F.R. Part 2, 45 C.F.R Parts 160 & 164 and by Wisconsin Statute 146.82 Confidentiality of Patient Health Care Records, 51.30 Mental Health Act, and 146.83 Access to Patient Health Care Records. Federal regulations prohibit you from making any further disclosure of this information without specific written consent of the person to 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.

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For Office Use -- Please check and date one option to ensure proper handing of Release of Information:

_________ **No Action Needed** at this time -- document, scan, attach to patient electronic record

_________ **Obtain Information** (from: Party/To: Eclipse Counseling) Date Request Sent: _________________

_________ **Send Information** (From Eclipse Counseling/To: Party)

_________ **Send Copy of Release to Allow Future Exchange** Date Sent: _________________