Client Release of Information

I, _____, hereby consent to the disclosure of the specific information listed in this document.

By and Between: Lake Country Wellness & Counseling
285 Forest Grove Dr., Suite 210
Pewaukee, WI 53072
Ph. 262-691-2980 Fax 262-691-4966

To and Between: _____
Name of Person

_____
Name of Organization

_____
Address

_____
Phone and Fax Numbers

The purpose or need for this disclosure is _____

Types of information to be disclosed_____

_____

I understand that the specific type of information to be disclosed includes diagnosis, prognosis and treatment for: AODA/mental health–complete chart including: client info, financial info, rights info, informed consent, psychosocial assessment, mental status, treatment plans, chemical usage form, chemical usage questionnaire, all consents, staffing info, group notes, progress notes, discharge summary and any other information found in chart. I understand that I have the right to inspect and, upon paying any applicable fees, obtain a copy of these disclosed records.

The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws. The consent is subject to revocation at any time and, in any case, expires:

_____
(Date, event, condition upon which consent will expire)

If date, event or condition is not indicated above, consent will expire in one year following date of signature

Revocation of consent honored by written notification only

_____ _____
Signature of Patient Person Authorized to Consent for Patient

_____ _____
Date Date

_____
Relationship*

_____ _____
Witness Reason*

* Mandatory for Relationship and Reason to be completed when someone other than patient signs consent.