

WETZEL-RASMUSSEN COUNSELING SERVICES

Name of Contracted Independent Provider: _____

WETZEL-RASMUSSEN COUNSELING SERVICES
W10610 Clinic Street, PO Box 278
Elcho WI 54428-0278
(715)275-3934
Fax: (715) 275-4533

Consent For Release of Information
To Insurance Company/Third Party Payor

Client Name: _____ **Date of Birth:** _____

Name of Insurance Company: _____

Address: _____

Phone Number: _____

I give my consent for Wetzel-Rasmussen Counseling Service to exchange the following information with my insurance company verbally and/or in writing:

<input checked="" type="checkbox"/> Treatment Records	<input checked="" type="checkbox"/> Recommendations
<input checked="" type="checkbox"/> Case Notes	<input checked="" type="checkbox"/> Treatment Plan
<input checked="" type="checkbox"/> Evaluations	<input checked="" type="checkbox"/> Psychological Tests/Screeners

Other information to be shared: _____
For the purpose of: Collaboration and payment

Client Name: _____	Guardian Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

This consent will be existent for one year from the date of the signing. It may be terminated or extended at the request of the client.

Please, review and initial back page

REDISCLASURE NOTICE TO PATIENT:

I understand that if the person(s) and/or organization(s) listed are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose my health information.

DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS:

Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written consent of the person who is the subject of such records.

DISCLOSURE NOTICE TO RECIPIENT OF MENTAL HEALTH, ALCOHOL AND/OR DRUG TREATMENT RECORDS:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- Right to receive copy of this authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- 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 above may not condition treatment, payment, enrollment in a health care benefits on my decision to sign this authorization except regarding:
 - Research-related treatment
 - Health plan enrollment or eligibility
 - The provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- Right to withdraw this authorization – I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Health Information Management (medical records) department. I understand that any cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- Right to inspect a copy of the health information to be used or disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Management (medical records) department.
- Mental Health treatment records – I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.06 of the Wisconsin Administrative Code.

Please, review and initial back page

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Initials _____

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