In Focus Counseling

11501 N. Port Washington Road, Suite 210
Mequon, WI 53092
Phone: 262.241.8901

AUTHORIZATION FORM

I ____, hereby consent to the disclosure of the specific information listed in this document regarding: ____
(Name of patient) (Date of birth)

by ____
(Name/address of person/organization making disclosure)

to ____
(Name/address of person/organization receiving information)

for the purpose of ongoing diagnosis, treatment planning, social, vocational and educational planning, and/or evaluation for legal representation.

The disclosure of the following checked, specific information is authorized:

- ☐ Dates of treatment
- ☐ Diagnosis
- ☐ Medical history and medications
- ☐ Psychiatric, social, psychological and other allied health evaluations
- ☐ Reports of progress and treatment
- ☐ School reports
- ☐ Drug and alcohol

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Upon termination from In Focus Counseling this authorization shall expire, or on the date specified: ____________.

____
(Patient signature) (Date)

________________________________ ________________________________
(Witness) (Person authorized to consent for client)