MEQUON CLINICAL ASSOCIATES
1045 West Glen Oaks Lane, Suite 1
Mequon, WI 53092
P: 262-241-8100 | F: 262-241-8200

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name: _____ DOB: _____

I hereby request: _____
(MCA Therapist's Name)

____ Disclose Information To: and/or ____Obtain Information From:

_____
(Name)

_____
(Complete Address)
Phone: _____ Fax: _____

Information to be Disclosed / Obtained:
____ Complete Mental Health Record
____ ***Only*** the following information: (Client must initial each item to be released / obtained)
- ____ Treatment Recommendations
- ____ Diagnosis / Assessment
- ____ Expected Length of Treatment
- ____ Treatment Plan
- ____ Session Dates Only
- ____ Progress Report on my Treatment
- ____ Other (specify): _____

____ Complete Medical Record
____ ***Only*** the following information: (Client must initial each item to be released / obtained)
- ____ Labs
- ____ Medication List
- ____Induction Records
- ____ Other (specify): _____
- ____ Records from Inpatient Stay (please note dates) _____

The Purpose of this Disclosure:
____ to permit continuity of care
____ to permit case collaboration
____ to permit case management (including reimbursement and processing of benefits)
____ other (specify): _____

I understand that this authorization may be revoked by me at any time by written notice to the Clinic Director and / or Therapist. I further understand that any information released prior to a request to revoke permission cannot be retrieved. I am voluntarily signing this authorization.

_____ _____
Signature of Patient Signature of Authorized Representative

_____ _____
Date Witness

Note to recipient: This information has been disclosed to you from confidential records, which are protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it 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.