LIVING WELL CHRISTIAN FAMILY CLINIC

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION
(PLEASE COMPLETE IN FULL)

____
Name of Client – Last, First, MI | Birthdate | Phone Number

____
Street Address | City | State | Zip

Authorizes:

Living Well Christian Family Clinic, LLC
575 Lester Ave, Suite 100
Onalaska, WI 54650

To Use and Disclose Protected Health Information to:

____
Name of person or organization

____
Street Address

____
City, State, Zip | Phone Number

Initial box to allow the above parties reciprocal exchange of Protected Health Information

Type of Information to be Disclosed:
Psychiatric Evaluation
Psychological Evaluation
Medical Information
Alcohol / Drug Abuse
School Records / Teacher Observations
Assessment and Psychotherapy Note
Information required to bill third party for services
Verbal or written information pertaining to treatment
Other ______________________________

Purpose of Information:
To facilitate counseling / therapy
To facilitate educational planning
To facilitate psychological evaluation
Payment of third party / insurance claim
Legal Investigation
Coordinate care with physician
Other ______________________________

Re-disclosure Notice: I understand that if the person(s) and/or organization(s) listed above 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 and my health information may be re-disclosed by such person(s) and/or organization(s) without obtaining my authorization.

Revocation of Authorization: I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency I authorized to release information.

I have a right to inspect and receive a copy of the records to be disclosed. I have a right to receive a copy of the authorization. I have a right to refuse to sign the authorization. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization.

If this authorization is for the purpose of filing an insurance claim, all benefits will be paid directly to Living Well Christian Family Clinic.

A fee may be charged for copying costs.

Expiration Date:

Authorization expires after payment owed by third party payor is complete.
Authorization expires as of ______________________________
Authorization expires 12 months from the date of this signed authorization
Other: ______________________________

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_______________________________ | _______________________
Client Signature | Date Signed

_______________________________ | _______________________
Signature of Client's Legal Representative | Relationship to Client