

# MEQUON CLINICAL ASSOCIATES

Concord Corporate Center • 11501 N. Port Washington Rd., Suite 202 • Mequon, WI 53092  
Phone: 262-241-7778

## AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

I hereby request: \_\_\_\_\_

(MCA Therapist's name)

Disclose information and/or  Obtain Information

to / 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): \_\_\_\_\_

Form in which information can be released:

verbal

photocopied

written

other \_\_\_\_\_

The purpose of such disclosure is:

to permit continuity of care

to permit case collaboration

to permit case management (including reimbursement determinations and processing of benefit)

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 understand that the therapist or facility noted above will not condition treatment or payment on the signing of this form.

I am voluntarily signing this authorization.

\_\_\_\_\_  
Signature of patient / client

\_\_\_\_\_  
Signature of parent, guardian or authorized  
representative (when required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

### NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from confidential records which may be protected by federal or state law. If the records are protected, Federal and State laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by Federal and State laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose.