Robert E. Berry House, Inc.
178 Sixth Street
Fond du Lac, WI 54935
920-922-8580 • Fax: 920-922-8609
email: berryprograms@gmail.com

Robert E. Berry House, Inc.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____DOB:_____

Authorize Robert E. Berry Halfway House Inc. to **DISCLOSE TO/OBTAIN FROM (circle one or both):**

_____

(Name of Person and/or Organization) FAX

_____

(Address/City/State/Zip) Phone

The following written and verbal information:

___Evaluation
___ Summary of Services
___Discharge Summary
___Progress Notes
___ Psychological, Psychiatric Evaluation/Diagnosis
___Substance Abuse Assessments
___Substance Abuse Treatment Plan/Summary
___Drug Screen Results
___Confirmation Letter to Referral Source
___Medical Records Including Special Tests/ Medications
___Medical Evaluation and Treatment
___ Other (Specify): _____
_____
_____

For the purpose(s) of:

___Facilitate family/significant other involvement
___Obtaining formal referral for treatment
___Coordination of Treatment/Services
___Establishing Individual Service Plan, and/or services
___Provision of primary services and treatment
___Providing information relevant to legal proceedings
___ Providing referral source with treatment progress
___Providing information to facilitate referral
___Other (Specify): _____
_____
___ Electronic transfer of information, including Internet/Faxing
Fax #/Internet Address: _____

Completion of this form authorizes the release of information described in the section above called "the following written and verbal information". The person (Client) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for mediation/ somatic treatment records, a director/ designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis., Stats., HFS 92.03-92.06 Wis. Admin. Code.

I understand that my records are protected under the Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described below.

I understand that if the person(s) and /or organization listed above are not health care providers, health plans, or health care clearing houses, who must follow the federal privacy standards, 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 without obtaining my authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____or for one year from the date signed. 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.

I further acknowledge that this information to be released was fully explained to me and this consent is given of my own free will. **A photocopy or facsimile of this signed form is valid as the original.**

SIGNATURE OF CLIENT/LEGAL REPRESENTATIVE: _____

DATE:_____ (If signed by other than the patient, state relationship and authority in which to sign for patient, i.e. minor, guardian,payee)

DATE: _____ (If signed by other than the patient, state relationship and authority in which to sign for patient, i.e. minor, guardian, payee).