Oakwood Clinical Associates, Ltd.

4109 67th Street, Kenosha, WI 53142   Phone 262-652-9830   Fax 262-652-2931

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ____ (DOB: _____________________),
do hereby give my authorization for Oakwood Clinical Associates, Ltd. to (check one or both)
_____ disclose and/or _____ obtain information from:

Name: ____ Relationship: _______________

The specific information to be USED OR DISCLOSED from Oakwood:

- ❑ Dates of Treatment
- ❑ Type of Treatment Provided
- ❑ Diagnosis
- ❑ Diagnostic Assessment
- ❑ Psychiatric Evaluations
- ❑ Treatment Plan
- ❑ Progress Notes
- ❑ Progress Reports
- ❑ Aftercare Plan
- ❑ Discharge Summary
- ❑ Patient Status (Active or Discharged)
- ❑ Other ___________________________

The specific information to be OBTAINED from the above named source:

- ❑ Type of Service
- ❑ Dates of Service
- ❑ Diagnosis
- ❑ Assessment
- ❑ Progress Notes
- ❑ Progress Reports
- □ Behavioral Information
- Legal Information Affecting Client
- ❑ Medical/Physical History
- ❑ Academic Performance
- ❑ Psychiatric Evaluations
- ❑ Discharge Summaries
- ❑ Other _________________________

This release is for the PURPOSE of:

- ❑ Initial Treatment
- ❑ Coordination/Continuation of Care
- ❑ Case Management/Utilization Review
- ❑ Legal Intervention
- □ Other_____________________________

This release will expire:

- ❑ On Receipt of Information
- ❑ One Year
- ❑ 30 Days after Discharge from Oakwood
- ❑ Other ______________________________

Client Signature:____
Parent/Guardian:____
Date:____
Witness:____

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL CONFIDENTIALITY REGULATIONS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION ANY TIME, IN WRITING, EXCEPT IF THE INFORMATION HAS ALREADY BEEN DISCLOSED PER THIS AUTHORIZATION.