Moontree Psychotherapy Center, LLC

401 Wisconsin Avenue, Madison WI 53703
608-256-5115

1	I, _____[Insert Name of Client], whose Date of Birth is _____, authorize Moontree Psychotherapy Center, LLC
2	☐ To release information to: ☐ To obtain Information from: (Check one or both) Agency/Individual: _____ Street/City/State/Zip:_____
3	I authorize the following types of treatment information to be disclosed: ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol & Other Drug Abuse ☐ HIV test results ☐ Other (Specify):_____
4	For the Following Date(s): From_____ To_____.
5	I authorize the following information to be disclosed: _____ Presence/Participation in Treatment _____ Psychiatric/Psychosocial Evaluation _____ Treatment Plan or Summary _____ Progress in Treatment _____ Medication Management Information _____ Nursing/Medical Information _____ Discharge/Transfer Summary _____ Continuing Care/Aftercare Plan _____ Psychological Testing _____ Other_____
6	The purpose of this disclosure of information is: ☐ Assessment/treatment planning ☐ Coordination of treatment ☐ Aftercare/continuation of treatment ☐ Other:_____
7	This consent (unless revoked sooner) expires on the following date: _____ or after 12 months if no date is provided.

I understand that:

1) This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:_____(Explain consequences of refusal to release information, if any)
2) I may revoke this authorization by sending written notice to the Privacy Officer at Moontree Psychotherapy Center, LLC, except to the extent that information has already been disclosed based on this release.
3) I will receive a copy of this form and have a right to inspect/receive a copy of the materials to be disclosed.
4) If my health information is disclosed to individuals or organizations not subject to HIPAA, it may no longer be protected by HIPAA.
5) My records are protected under the following state and federal regulations: Sec. 51.30, WI Statutes; HFS 92, WI Admin. Code; 42 CFR, Part 2; Health Insurance Portability and Accountability Act of 1996, 45 CFR, pts 160 & 164
6) Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____

Signature of Patient/Client Date

_____

Signature of ☐ Parent ☐ Guardian ☐ Other:_____(Check One) Date

_____

Signature of Staff Witness Date