AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

I authorize, and/or request

FAMILY RESOURCES ASSOCIATES, INC.
1315 W. Main Street, Watertown, WI 53094 (920) 261-4100 Fax (920) 261-8801
331 N. Main Street, Lake Mills, WI 53551 (920) 648-3896

To Release to _____ and/or _____ Obtain from (check one or both)
Agency/ Individual: _____
Address: _____

The following specific information from the records of:

Client Name: _____ DOB: _____

Specific Records Authorized for Release (Include dates of records, if applicable.)

PLEASE CHECK RECORDS TO BE RELEASED _____VERBAL _____WRITTEN

_____ ELECTRONIC TRANSMISSION
(Includes- **Faxes, E-mail & Voice mail)**

1. ____ Medical Diagnostic and treatment records
2. ____ Psychiatric diagnostic and treatment records
3. ____ Long term support records
4. ____ Alcohol and drug abuse treatment records
5. ____ Child protective services records
6. ___ Marriage, divorce records
7. ___ Court records
8. ___ Law enforcement records
9. ___ School records
10. ___ Other _____

Purpose or Need for Release of Information (be specific)
PLEASE CHECK PURPOSE THAT APPLIES (at least one must be checked for authorization to be valid)

For the provision of:
___ Psychotherapy
___ Coordination of case
___ Psychological Evaluation
___ Court ordered Services
___ Case Management
___ Other _____

I understand that I may revoke this authorization, in writing, at any time, except when information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated below. **(An expiration must be indicated below for the authorization to be valid.)**
___ Authorization expires as of _____ (date)
___ Authorization expires _____ month(s) from the date I sign this authorization
___ Authorization is for records acquired during _____ (time period)
___ Authorization expires after the following action takes place: _____

The individual who is the subject of the records covered by this authorization, in most cases has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director or designee, during the individual's treatment under certain circumstances. A uniform and reasonable fee may be charged to copy the records; the fee may be reduced or waived in accordance with agency policy for those individuals who show inability to pay. This authorization form is intended to be in conformance with Section 51.30 (4) (d) Wisconsin Statues; Sections HSS 92.03 (3) (d), 92.05, 92.06 Wisconsin Administrative Codes; Sections 49.53, 51.30 (2) 146.82 WI Status; title 45 Code of Federal Regulations, Sections 205.50, and 205.59.

Signature of Individual (14 or older) Date

Signature of Person Legally authorized to consent for the above individual Relationship Date
(parent or guardian must sign if under 18, clients between 14-18 require both signatures)

Revised 12/23/08