



PRENTICE HOUSE INC.

PO Box 891 + 517 Beaser Avenue + Ashland, WI 54806 + 715.682.1160 + f:715.682.6101 + info@prenticehouse.org

SPECIAL AUTHORIZATION FOR RELEASE

First Name Mi. Int. Last Name Date of Birth

I do hereby consent to and authorize **Prentice House Inc.** to ___ disclose to and/or ___ obtain from:

Name of Health Facility, Individual's Name(s), Attorney, Social Worker, etc...

Street address and/or P.O. Box

City State Zip Code

Information from the records maintained while I am/was involved with this facility or individual(s).
The specific information to be disclosed is as follows:

- Verbal Progress Report.
- Progress Notes.
- Substance Use Disorders Diagnostic Schedule and/or Alcohol Use Profile.
- BioPsychoSocial Evaluation and/or Multi-Disciplinary Data Base.
- Psychological Evaluation and/or psychological testing, consultation, and/or therapy summaries.
- History and Physical and/or physical testing
- Psychiatric Evaluation and/or testing, psychiatric consultation, and/or therapy summaries.
- Therapist or Counselor Discharge Summary/Aftercare Plan.
- Adolescent Home Contract.
- Medical Discharge Summary.
- Educational: Grades, testing results, behavioral observations, evaluation results and recommendations.
- Other: _____

The purpose or need for this disclosure is to aid in:

- The continuity of care.
- Evaluation and/or placement.
- Determine eligibility of insurance.
- Other: _____

I understand that authorizing the disclosure of this information is voluntary. I understand that my records cannot be released without my written consent unless otherwise specified by law. I understand that the expiration date is my discharge date at Prentice House Inc. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. A photocopy or faxed copy of this consent will be accepted as an original. We reserve the right to request the original.

Resident/ Client/ Patient Signature

Date

Parent/ Legal Guardian/ Authorized Representative

Witness Signature

Note to Release Recipient: This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Federal Regulations (42 CFR-Part II) and Wisconsin Statutes 51.30 and 51.61 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.