2620 W. STEWART AVENUE, SUITE 310, WAUSAU, WI 54401
PHONE: (715) 848-0525 FAX: (715) 848-8665

CHARIS COUNSELING LLC

101 W. MCMILLAN STREET, MARSHFIELD, WI 54449
PHONE: (715) 389-9382 INFO@CHARISCOUNSELINGWI.COM

Authorization for use and disclosure of protected health information

I am completing this form to allow the use and sharing of protected health information (PHI) about:

Printed Client Name: _____ Date of Birth: _____

I authorize: Charis Counseling, LLC.
2620 West Stewart Avenue, Suite 310
Wausau, WI 54401
Phone: 715-848-0525 Fax: 715-848-8665

☐ **To Disclose to** ☐ **Receive from** ☐ **Exchange with**

Name: _____

Address: _____

Phone: _____ **Fax/Email:** _____

☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness, or drug and/or alcohol abuse.
☐ Admission and discharge summaries
☐ Psychological, psychiatric, social work, or counseling evaluation(s), reports, assessments, treatment notes, testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
☐ Treatment, recovery, rehabilitation, aftercare plans and other similar plans
☐ Evaluations and reports of consultants
☐ Progress, nursing, case, or similar notes
☐ Verbal Communication
☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here.
☐ Do not release these

☐ Information about how the patient's condition(s), affects or has affected their ability to work and to complete tasks or activities of daily living
☐ Social, family, educational, and vocational histories
☐ Academic and educational records, including achievements and other tests' results, reports of teachers' observations, and all other school or special education documents.
☐ Billing Records
☐ Vocational evaluations and reports
☐ Other: _____
☐ Scheduling appointments

Dates of service: From: _____ To: _____
IF nothing is filled in, only the last year of records will be given.
The information will be used/disclosed for the following purposes: _____
_____

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the person or organization listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that received the information is not a health care provider or health plan covered by the federal privacy regulations, the information above may be redisclosed and no longer protected by those regulations.

I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. ☐ Does not apply

I affirm that everything in this form that was not clear to me has been explained and that I believe I now understand all of it. I acknowledge that I have received a copy of this completed form.

If not revoked earlier, this authorization expires on: _____ **(date)** not to exceed one year of signature date.

Signature: _____ Date: _____

Printed Name: _____ Phone #: _____

Relationship to client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____

Fax/Copy effective as original
Encouraging Excellence in Living