Lucinda Thimm-Jurado, MSSW, LCSW
Wisconsin Therapy Center LLC
6410 Enterprise Lane, Suite 130
Madison, WI 53719
Phone: (608) 819-8800
Fax: (608) 819-8899

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION AND RECORDS

PATIENT INFORMATION

Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

I hereby authorize and request **Wisconsin Therapy Center LLC / Lucinda Thimm-Jurado, LCSW**

❑ To Release Information To: ❑ To Obtain Information From: ❑ Contact By Telephone Only

Person / Organization:			
Address:			Phone:
City:	State:	Zip:	Fax:

PURPOSE OR NEED FOR DISCLOSURE (Check those that apply)

❑ Evaluation / Assessment	❑ To Coordinate Care
❑ Other (specify):	

INFORMATION TO BE DISCLOSED (Check those that apply)

❑ Intake Evaluation (incl. diagnosis/prognosis)	❑ Psychotherapy Progress Notes	❑ Psychological Testing / Evaluation
❑ Medical Records	❑ Hospital Records	❑ AODA Evaluation / Treatment
❑ School Functioning, IEP or Test Results	❑ Admission / Discharge Summaries	❑ Aftercare Plan
❑ Treatment Plans	❑ Psychiatric Evaluation / Consultation records	❑ Social History
❑ Other (specify):		

This authorization will remain in effect until the above disclosure(s) have been completed, unless you specify that this authorization will be effective for an additional time period.

(To specify an additional time period, please check one of the boxes below. ***NOTE:*** *If you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)*

❑ Other specific expiration date: ________________________ (mm / dd / yy)

❑ 15 Months from date signed

PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol and drug treatment, AIDS or AIDS-related illnesses and/or HIV test results, with the following exceptions:

____

Signature of Client: ____ Date: ______________

Name of of Other Person Authorized
to Consent Disclosure (please print): ________________________ ________________________ Date: ______________
(Name) (Signature)

Client is: ❑ Minor ❑ Incompetent / Incapacitated ❑ Deceased

If Authorized Person is other than client, indicate legal authority by checking the appropriate box below.

❑ Parent of Minor ❑ Legal Guardian ❑ Next of Kin ❑ Power of Attorney

Witness / Therapist Signature: ____ Date: ____________________

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Wisconsin Therapy Center LLC honors a client's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, Wisconsin Therapy Center LLC providers may not refuse to provide you treatment or other health care service if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the first page of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Lucinda Thimm-Jurado, MSSW, LCSW, Wisconsin Therapy Center LLC, 6410 Enterprise Lane, Suite 130, Madison, WI, 53719

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact Lucinda Thimm-Jurado, MSSW, LCSW, Wisconsin Therapy Center LLC, at (608) 819-8800.

Copying Fees. You and/or the facility to whom your medical information is released may be charged a reasonable & customary fee for copying your medical records.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact:
Lucinda Thimm-Jurado MSSW, LCSW, Wisconsin Therapy Center LLC, at (608) 819-8800.

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