Monica C Roman, LPC
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Greenfield, WI 53220
(414) 305-8285

Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ **I authorize Monica Roman, LPC to release information to:**

AND/OR

☐ **I authorize Monica Roman, LPC to obtain information from:**

Name of Provider, Facility or Person: _____

Address: _____

Phone: _____ **Fax:** _____

SPECIFIC INFORMATION AUTHORIZED TO BE DISCLOSED: (select one or more as appropriate)

☐ Progress Notes ☐ Diagnosis ☐ Treatment Plan ☐ Counseling Attendance

☐ Discharge Summary ☐ Scheduling / Payment Info ☐ Mental Health Record Summary

☐ Other: (please describe)_____

PURPOSE OF THIS REQUEST: ☐ Healthcare ☐ Family Involvement ☐ Billing Purpose ☐ Aftercare Planning

☐ Continuity of Treatment ☐ P.O./Attorney/Judge/Court ☐ Other:_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.

☐ 90 days from this date. ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire:**

☐ When I am no longer receiving services from the Monica Roman.

☐ One year from this date. ☐ Other: _____

The designated information about me ☐ **may** ☐ **may not** be transmitted by *fax, electronic mail or other electronic file transfer mechanisms*. Monica Roman and the above designated person ☐ **may** ☐ **may not** discuss by *telephone* the content of the information released.

I understand that:

- I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to the Monica Roman, except where a disclosure has already been made in reliance on my prior authorization.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.
- I hereby release all parties stated here with from any liability resulting from the release of this information.
- I agree that a photocopy of this release shall be as valid as the original.

Signature of Client (Parent/Guardian): _____ Date: _____

Signature of Monica Roman, LPC:_____ Date:_____