CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

☐ I request to have my information disclosed to: Guided Wellness Counseling, SC
5024 Greenbay Rd, Suite 140
Kenosha, WI 53144
Ph. (262) 287-1999

☐ I authorize Guided Wellness Counseling, SC to release my information to:

_____
_____
_____
_____

Information to be released or disclosed:

☐ Diagnosis ☐ Psychiatric and Psychological Evaluations
☐ Reports of Progress and Treatment
☐ Medications and Hospitalizations ☐ School or Employment Records

This information will be used for the following purposes:

☐ Treatment Planning ☐ Ongoing Diagnosis
☐ Social, vocational, employment, or educational planning
☐ Other: _____

I understand that my records may be protected under Wisconsin Law (WI stat. 51.30), governing the Confidentiality of Mental Health Records, and/or Federal Law (42 CFR, 2), and Confidentiality of Alcohol and Drug Abuse records. These records cannot be disclosed without my written consent unless otherwise provided for in these regulations. I understand I have the right to inspect and/or receive a copy of the material to be disclosed upon payment of reasonable charges for photocopy service. I also understand that I may revoke this consent at anytime, except (1) to the extent that action has been taken and in reliance on it, and (2) that my consent will expire one year following the date of signature unless otherwise indicated.

Date, Event, or Condition upon which this consent will expire: _____

Signature of Patient:_____ Date: _____

Signature of Guardian:_____ Date: _____

Witness:_____ Date: _____