North Shore Center, LLC

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name

Date of Birth

This authorizes North Shore Center, L.L.C. to ☐ **disclose** or ☐ **receive** from (check one or both):

Name of person, title and/or organization

Address, city, state, ZIP

The following written/verbal information:

No	Yes	
☐	☐	Treatment summaries/plan
☐	☐	Summary of all services
☐	☐	Progress notes from ____ to ____
☐	☐	Assessment results
☐	☐	Psychological evaluation
☐	☐	Recommendations
☐	☐	Psychiatric evaluation
	☐	Other (specify)

No	Yes	
☐	☐	Drug testing results
☐	☐	Social history assessment
☐	☐	Diagnosis only
☐	☐	Medications
☐	☐	Ongoing verbal exchange of information between two parties above

The purpose for the disclosure of the information is:

No	Yes	
☐	☐	A. To assist in evaluation and treatment planning
☐	☐	B. To facilitate family involvement in treatment/evaluation
☐	☐	C. To coordinate treatment services between providers
☐	☐	D. Other reasons (specify)

I understand that my records are protected under the Federal and Specific State confidentiality laws and regulations (initial on or both ☐ Chemical Dependency, Fed. Regs. 42CPR, Part 2. ☐ Mental Health, SS Chapter 51.30) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it and that, in the event, this consent expires automatically as described below.

THIS RELEASE EXPIRES UPON THE FULFILLMENT OF THE PURPOSE FOR WHICH THIS RELEASE WAS ENACTED AND IN ANY EVENT, SPECIFICALLY EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under as HSS 92.05 and 92.06 of the Wisconsin Administrative Code. These provisions apply to records maintained by an 51.42 agency, including the Ozaukee Department of Community Programs. I further acknowledge that the information to be released was fully explained and this consent is given of my own free will.

Patient Signature (adult/adolescent 14 years or older)	*Date*
Parent/Guardian Signature	*Date*