AUTHORIZATION FOR RELEASE OF CLINICAL INFORMATION

I, _____, D.O.B. _____/_____/_____, authorize

Susan Dellutri, LCSW, LMFT, CASC to
827 North Cass Street
Milwaukee, WI 53202
Ph. (414) 278-7980 X114
Fax (414)278-8299

____Release to
____Obtain from
____Exchange with

Individual/Agency _____
Address _____
Phone _____
Fax _____
Email _____

The following specific information from the confidential records:

____ BioPsychoSocial Assessment & History
____ Diagnosis
____ Treatment Plans
____ Psychotherapy Notes
____ Progress in Treatment
____ Presence/Participation in Treatment
____ Psychological Testing
____ Medication Management
____ Demographic Information
____ Discharge and/or Transfer Summary
____ Continuing Care Plan
____ Other: _____

The **Purpose** for releasing/obtaining these records is

____ Coordination of Treatment
____ Improve Assessment & Planning
____ Insurance Issues
____ Legal Purposes/Proceedings
____ Other: _____

I hereby **Release** Susan Dellutri, LCSW, LMFT, CASC, Susan Dellutri, LLC, Therapies East Associates, LLP, and its agents and officers from all legal responsibilities or liability consistent with this authorization.

The **Expiration** of this consent shall be 1 year from the date of signing or as indicated_____.

I understand that I have a right to **Revoke** this authorization, in writing, at any time by sending written notification to Susan Dellutri, LCSW, LMFT, CASC at 827 N. Cass St. Milwaukee, WI 53202.
I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I further understand that Susan Dellutri, LCSW, LMFT, CASC will not **Condition** my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

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Unless you have specifically requested in writing that the **Form of Disclosure** be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be **Redisclosed** by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I was offered a **Copy** of this authorization for my records. _____ (initials)

This information has been disclosed from records whose confidentiality is protected by **Federal (42 CFR Part 2) and WI (51.30) laws**. These laws prohibit redisclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations and statutes. A general authorization for release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE. Federal laws and regulations cited here provide that any person who violates these provisions shall not be fined more than $500 in the case of the first offense, and not more than $5,000 in the case of any subsequent offense.

Authorization Refusal _____
Date

_____
Client/Parent/Guardian Signature Date

_____
Relationship to the Client (Parent, Power of Attorney, Healthcare surrogate, etc)

_____
Witness Date