Alarus healthcare

AUTHORIZATION FOR RELEASE OF INFORMATION

Please circle appropriate clinic

1971 Washington St., Grafton, Wisconsin 53024 262-7-377-6276 Fax: 262-377-6289

PATIENT NAME:_____ D.O.B._____ S.S. # _____

I authorize Alarus Healthcare, LLC to ___release to ____obtain from (check one or both)

Individual Address:
Emergency Contact:_____
Address:_____
Phone:_____

SPECIFIC INFORMATION TO BE RELEASED BY Alarus Healthcare, LLC	YES	NO
History & Physical Exam	____	____
Psychological Evaluation	____	____
Psychiatric Evaluation	____	____
Staffing/ Progress Notes	____	____
Social Assessment	____	____
Aftercare Plan	____	____
Discharge Summary	____	____
General/Verbal Information	____	____
Urine Screen Results	____	____

SPECIFIC INFORMATION TO BE RELEASED TO Alarus Healthcare, LLC	YES	NO
History & Physical Exam	____	____
Psychological Evaluation	____	____
Psychiatric Evaluation	____	____
Social Assessment	____	____
Aftercare Plan	____	____
Discharge Summary	____	____
General/Verbal Information	____	____
Urine Screen Results	____	____
Other_____		

PURPOSE FOR THE DISCLOSURE OF INFORMATION:

A. To assist in the treatment process	YES	NO
B. To facilitate family involvement in treatment	YES	NO
C. Other reasons (specify reason if YES is circled)	YES	NO

Emergency

I hearby hold Alarus Healthcare, LLC and it's agents and officers harmless from any acts taken consistent with this authorization. I am also aware that I have the right of access to any information received from or relased to Alarus Healthcare, LLC I understand that reports relased may include psychiatric, alcohol and/or drug abuse records. This consent may be revoked by me at any time, except to the extent that action ahs been taken in reliance thereon. I also understand that this consent, unless revoked earlier, shall be valid for one year and that a copy of this release will be considered as valid as the original. This release is executed in conformity with 42CFR, 2.31(b) and Health Insurance Portability and Accountability Act of 1996 ("HIPPA") I understand that I am under no obligation to sign this form and that the person and/or agent listed above who I am authorizinig to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization.

_____ Date:_____
Signature of Patient

_____ Date:_____
Signature of Parent or Guardian (if client is a minor)

_____ Date:_____
Signature of Witness

_____ Date:_____
Signature of Revocation