Alarus healthcare

Authorization For Release Of Information

Please Select Appropriate Clinic Location

☐	1971 Washington Street, Grafton, WI 53024	P 262.377.6276	F 262.377.6289
☐	1622 Chestnut Street, West Bend, WI 53095	P 262.306.9800	F 262.306.9802
☐	111 Warren Street, Beaver Dam, WI 53916	P 920.219.4440	F 920.219.4553

Patient Name: _____ D.O.B _____ Soc Sec.# _____

I Authorized Alarus Healthcare, LLC [X] To Release To [X] To Obtain From

Individual Address:

emergency contact → Contact:

Address:

Phone:

Specific Information to Be Released By Alarus

	Yes	No
History & Physical Exam		X
Psychological Evaluation		X
Psychiatric Evaluation		X
Staffing/Progress Notes		X
Social Assessment		X
Aftercare Plan		X
Discharge Summary		X
General/Verbal Information		X
Urine Screen Results	X	
		X

Specific Information To Be Released To Alarus

	Yes	No
History & Physical Exam		X
Psychological Evaluation		X
Psychiatric Evaluation		X
Social Assessment		X
Aftercare Plan		X
Discharge Summary		X
General/Verbal Information		X
Urine Screen Results	X	
Other EMERGENCY		X
	X	

PURPOSE FOR THE DISCLOSURE OF INFORMATION

A) To assist in the treatment process
B) To facilitate family involvement in treatment
C) Other reasons (specify reason if yes is circled)

Yes (No)
Yes (No)
Yes (No)

I hereby hold Alarus Healthcare, LLC and it's agents and officers harmless from any acts taken consistent with the authorization. I am also aware that I have the right of access of any information received from, or released to Alarus Healthcare, LLC. I understand that reports released 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 has 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,3.1(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 authorizing 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.

Signature of Patient _____ Date: _____

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

Signature of Witness _____ Date: _____

Signature of Revocation _____ Date: _____