Authorization to Use or Disclose Information

I hereby authorize Rainbow Marifrog, LLC and Rainbow Marifrog, MA, LMFT to: (check one)
☐Obtain ☐Disclose ☐Exchange personal and confidential information regarding:

Client: ____
First Name MI Last Name Date of Birth

I authorize the personal and confidential information of the aforementioned person to be released to and/or obtained from the following persons and/or agency:

Name: ____________________________________ Agency: __________________________________

Address: ____

Phone: ____________________ Fax: ____________________ Email: __________________________

The information I allow to be disclosed: (please check all that apply)

☐ Mental Health, including: progress, diagnosis, evaluations, assessments, attendance
☐ Psychotherapy notes
☐ Psychological testing/evaluation
☐ Psychiatric Evaluation/Consultation Records/Psychological Medication (current and history)
☐ Social, family, educational and vocational histories
☐ Information about how the client's condition(s) affects or has affected his/her ability to work, and/or complete tasks or activities of daily living.
☐ AODA evaluation/treatment
☐ Inpatient hospitalization
☐ Other: ____
Specific information I do not want disclosed: _______________________________________

The purpose of this disclosure is: (please check all that apply)

☐ Mental health evaluation/treatment
☐ Psychiatric evaluation/treatment
☐ Psychological testing/evaluation
☐ Legal interface
☐ Coordination with school
☐ Coordination of treatment
☐ Other: ______________________________

I understand that this authorization is in effect until 90 days after the termination of treatment or until _____________________________________, unless otherwise revoked through written notice.

By signing this authorization, I acknowledge my understanding that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made according to my directions. I affirm that everything in this form that was not clear to me has been explained and I now understand all of it.

Client Signature: ____ Date: _______________

Legal Guardian Signature *(if minor)*: __________________________________ Date: _______________

Witness Signature: ____ Date: _______________

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Rainbow Marifrog, LLC and Rainbow Marifrog, MA, LMFT honor your right to confidentiality of medical information as provided under federal and state law. Please read the following before signing this form.

No Obligation to Sign. You may refuse to sign this authorization. Except as permitted under applicable law, Rainbow Marifrog, LLC may not refuse you treatment or other health care services if you refuse to sign this form. However, if you refuse to release this information by signing this form, it could result in a failure, for example, to properly coordinate your treatment with other health care providers such as your psychiatrist or primary physician, thus making your treatment less effective. Depending on your specific situation, other potentially harmful effects could occur.

Revocation. You have the right to revoke or cancel this authorization at any time, except to the extent information has already been shared based on this authorization. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional.

Re-release. If the person(s) and/or organization authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under federal and state law. If you would like to inspect your records, contact Rainbow Marifrog, LLC. In accordance with WI Statute 51.30 [Patient Access s.51.30(4)(d)3], inspection of a record shall be done with your clinician present.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You may be charged for copies you request for other purposes.

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