Craig L. Abrams, Ph.D.
1001 W. Glen Oaks Lane, #206
Mequon, WI 53092
414.628.4848

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: ______________________________________ DOB: _________________

I AUTHORIZE:	**TO EXCHANGE PHI WITH:**
__**Craig L. Abrams, Ph.D.**__________	___________________________________
Individual or Organization	Individual or Organization
__**1001 W. Glen Oaks Lane, #206** ____	___________________________________
Address	Address
___**Mequon, WI 53092**_____________	___________________________________
City, State, Zip Code	City, State, Zip Code

FOR THE PURPOSE OF:
__________Continuity of care____

i.e., at the request of the client for his/her own use, continuing care, case management, authorizing continued treatment, payment of benefits, etc. The type and amount of information to be used or disclosed is for the following dates:

From: __________________________ to: ____________________________

[ ] AODA and/or Psychiatric Discharge Summary which may include HIV information

[ ] AODA and/or Psychiatric Reports
[ ] Psychological Reports
[ ] Lab/X-ray Reports
[ ] Social Worker/Case Manager Reports
[ ] Dr. Progress Notes/Order
[ ] Consults
[ ] Nurses Notes
[ ] OT/RT Reports
[ ] Physical Examinations
[ ] HIV Testing Results/AIDS Related Reports
[ ] Treatment Plan
[ ] Miscellaneous Reports (Please specify):____

[ ] Yes [ ] No If necessary, I authorize the use of a facsimile (fax) machine in disclosing this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to my Provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date:

____.

If I fail to specify an expiration date, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary and I need not sign this form in order to assure treatment.* I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy standards. If I have questions about the disclosure of my heath information, I can contact my psychologist, case manager, or physician at the address above.

____ _________________________
Client Signature Date

____ _________________________
Parent/Legal Guardian/Authorized Representative Relationship/ Date

____ _________________________
Witness Signature Date

This confidential copy of the case record may not be duplicated, copied or disclosed without the informed consent of the individual to whom the information pertains.

*Provision of research-related treatment or treatment that is for the sole purpose of creating health information for disclosure to a third party will not be provided without your written authorization.