SPECTRUM HEALTHCARE

6416 SOUTH HOWELL AVE. OAK CREEK, WI. 53154; P: 414-304-5713 F; 414-304-5721

RELEASE OF INFORMATION FORM

Patient name: _____ DOB: _____ Phone: _____

Patient address: _____

I authorize Spectrum Healthcare to release to [ ] obtain from [ ] the following individual/agency

Name: _____ Phone: _____

Address: _____

Specific information to be **RELEASED BY** Spectrum Healthcare:	YES	NO	Specific information to be **RELEASED TO** Spectrum Healthcare:	YES	NO
History & Phy. Exam	_____	_____	History & Phy. Exam	_____	_____
Initial Assessment	_____	_____	Initial Assessment	_____	_____
Psychiatric Eval.	_____	_____	Psychiatric Eval.	_____	_____
Progress and/or Notes	_____	_____	Progress and/or Notes	_____	_____
Treatment Plan	_____	_____	Treatment Plan	_____	_____
Discharge Notes	_____	_____	Discharge Notes	_____	_____
Drug Screens	_____	_____	Drug Screens	_____	_____
General/Verbal	_____	_____	General/Verbal	_____	_____
Information	_____	_____	Information		
Other_____			Other_____		

PURPOSE OF DISCLOSURE OF INFORMATION:

1. To assist in the treatment process: YES NO
2. To facilitate family Involvement: YES NO
3. Other reasons (specify below if yes): YES NO

_____

I hereby hold Spectrum Healthcare and its 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 released to Spectrum Healthcare. I understand that reports released may include psychiatric, alcohol and/or other drug abuse records. This consent may be revoked by me at any time, except to the extent that action has been take 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).

SIGNATURE OF PATIENT_____ DATE:_____

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

SIGNATURE OF WITNESS_____DATE_____

SIGNATURE OF REVOCATION_____DATE_____