Collective Voices
P.O. Box 243
Dodgeville, WI 53533
Phone: 608-347-1432
Email: collectivevoices2019@gmail.com

RELEASE OF INFORMATION

I authorize the following health information to be used and/or disclosed, including information that is otherwise confidential and protected, as further specified below.

_____

Client Name Date of Birth

_____ (____)_____

Street Address City/State/Zip Code Phone

INFORMATION TO BE USED AND/OR DISCLOSED:

1) I authorize the use or disclosure of protected health information to be released **FROM:**

Individual/Agency:

_____

Address: _____ Phone: _____

2) I authorize the use or disclosure of protected health information to be released **TO**:

Collective Voices
PO Box 243
Dodgeville, WI 53533

3) In compliance with WI statutes that require special permission for release of privileged information, I authorize the use or disclosure of records pertaining to (check all that apply):
❑ Mental Health ❑ Alcohol &/or Drug Abuse ❑ Other (specify): _____

This authorization is good until (indicate expiration date - month, date and year): _____

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The expiration date of this release refers to the date after which all entities listed above can no longer request records or communicate on my behalf.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- Right to receive a copy of this authorization – I understand that by signing this authorization, I will be provided with a copy of this authorization upon request.

- Right to withdraw this authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the above-named provider. I am aware that my withdrawal will not be effective until received by the provider and will not be effective regarding the uses and/or disclosures of my health information that the provider has made prior to my withdrawal statement.

I understand that information used or disclosed based on this authorization is for services through Collective Voices. The release may be subject to re-disclosure and no longer protected by federal privacy standards. I am aware that services are not contingent upon the decision concerning the release of information. I hereby release the above institutions and/or persons from legal responsibilities, or liabilities that may arise from this act. A copy of this release shall be considered as valid as the original. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____

Signature of client or legal representative Date

_____

Provider's name (print and sign) Date