Michael Noll Counseling

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AUTHORIZATION FOR THE USE FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (PHI)

Client Name _____ DOB: _____

I AUTHORIZE	**DISCLOSE TO/RECEIVE FROM**
Michael Noll Counseling, LLC _____ Organization	_____ Individual or Organization
1477 Kenwood Dr, Suite 200 _____ Address	_____ Address
Menasha, WI 54952 _____ City, State, Zip	_____ City, State, Zip

TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED: (check all applicable boxes)
__ Discharge Summary __ Lab Results __ Progress Notes __ Other: _____
__ Psychological Testing __ Complete Mental Health Record __ Medication Log __ AODA Treatment

FOR THE PURPOSE OF:
__ Continuity of Care __ Transfer of Care __ Other: _____
__ Disability Determination __ Worker's Compensation Claim __ Court Case __ Personal

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) 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.

POTENTIAL FOR RE-DISCLOSURE - I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy statements.

RIGHT TO WITHDRAW THIS AUTHORIZATION - I understand that written notification is necessary to cancel this authorization. Unless otherwise revoked, this authorization will expire on the following date:

THIS AUTHORIZATION IS EFFECTIVE UNTIL: _____ *If no date is listed, this authorization will expire in one year.*

_____ Date: _____
Client/Patient Signature (14 years and older)

_____ Date: _____
Personal Representative Signature (State Relationship)