Mente Salus Psychological Services, LLC

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release." The person whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records.

Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Name of Person of Record

Address1

Address2

City, State, Zip

Phone Number

DOB | Gender ☐Male ☐Female

This Agency is being Authorized to ☐Release to ☐Exchange with ☐Receive from

Nina Albanese-Kotar, PhD
Mente Salus Psychological Services, LLC
4319 Jeffers Road, Suite 101
Eau Claire, WI 54703
715-839-7240
FAX: 715-839-7674

Coordinating Provider

Organization

Address

City, State, Zip

Phone | Fax

Specific Description of Records Authorized for Release (include dates of records if applicable):

☐Progress Notes only	☐Medical History & Notes	☐Consults
☐Psychiatric Evaluations	☐Prescriptions	☐Billing Records
☐Psychological Reports	☐Immunizations	☐Academic Records
☐Treatment plans, reviews, summaries	☐Hospital Records	☐Other, specify:

Purpose or Need for Release of Information (be specific):

☐Continuing care needs	☐Disability (for insurance or government)	☐Preemployment
☐Transfer of care	☐Billing, collection or payment of claims	☐Postemployment
☐Care coordination/case mgmt.	☐Employment determination (nonwork related illness or injury)	☐Sharing with relatives/others
☐Second opinion/referral		☐Other, specify:
☐Personal (fee for records)	☐Litigations (fee for records)	

Understandings: This authorization is voluntary, refusal to sign will not affect treatment, payment, enrollment or benefits eligibility. Exceptions: ☐ none ☐ exceptions , specify:_____

- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If the information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release the information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.
  Choose one:
  - ☐Authorization expires as of this date:_____
  - ☐Authorization expires _____ month(s) from the date I sign this authorization.
  - ☐Authorization expires after the following action takes place:_____

As evidenced by my signature, I hereby authorize disclosure of records to the person or agency specified above:

Signature (age 14 and up) Date:

Signature of Parent/Guardian of minor Relationship: Date:
(or Other Person Legally Authorized to Consent to Disclosure)