AUTHORIZATION FOR RELEASE OF INFORMATION

	Stonetree Therapy LLC 1108 Stephenson Lane, Suite 116 Waunakee, WI 53597 608-849-4161
1	I hereby authorize _____ of Stonetree Therapy LLC
2	Check one or both ☐ to obtain from and/or ☐ to release to Name &/or Agency_____ Street Address: _____ City/State/Zipcode: _____ Phone #: _____
3	Information from the records of: _____ _____ Date of Birth
4	For the Purpose: ☐ Treatment Planning ☐ Mental Health Evaluation ☐ Emergency Contact ☐ Other: _____
5	Type of information to be disclosed: ☐ Mental Health History &/or Evaluations ☐ HIV ☐ Medical ☐ Medication List ☐ Alcohol/Drug Abuse ☐ Intake & Discharge Summary ☐ Other _____
6	The records or information covering the dates From: _____ To: _____
7	I understand that my records are protected under State and Federal regulations governing confidentiality: Sec. 51.30 Wis. Stats. & DHS 92 Wis. Admin. Code, 42 CFR, Part 2. CLIENT RIGHTS: I also understand that I have the right to receive a copy of this authorization, right to refuse to sign this authorization and the right to withdraw this authorization in writing at any time except to the extent that at action based on this consent has already been taken. Further Disclosure: I understand that, if the persons or organization I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. This consent will expire automatically after 1 year from the date on which it is signed. _____ _____ Client's Signature Date Signed _____ OR Signature of Person Authorized to Consent Relationship to client Date Signed