AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____
(Name of Client) *(Birth Date)*

Authorize the Lake Area Technical College to: ☐ release to ☐ exchange with †

_____
(*Name of agency or organization or person to which disclosure is to be made*)

The following information from my clinical/medical/academic-educational records:

☐ Assessment
☐ History
☐ Psycho-Social History
☐ Progress Notes
☐ Treatment Plans
☐ Police Reports
☐ Diagnostic Statements/Impressions
☐ Educational-Academic Testing/Results
☐ Compliance
☐ Current Functioning
☐ Incident/Sanction Reports
☐ Treatment Progress
☐ Recommendations
☐ Medical History
☐ Psychological Testing/Results
☐ Discharge Summary

☐ Other _____

The purpose of the disclosure authorized in this consent is for:

_____
(C*oordination of services, collateral information, further treatment, disability claim, etc.*)

I understand that my counseling records at Lake Area Technical College are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 C.F.R. pts 160 &164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time.

This consent will expire automatically upon completion of counseling or treatment services, completion of actions related to judicial processes, or one (1) year.

For Recipients PROHIBITION OF REDISCLOSURE:
This information has been disclosed to you from records the confidentiality of which is protected by Federal Laws. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____
Signature of Client *Date*

X_____ Permission to use electronic transmission to send information (fax, email).
Initials

_____
Witness *Date*

LAKE AREA TECHNICAL COLLEGE

FOR OFFICE USE ONLY

Sent to:
Sent by:
What information:

Mode of delivery:
Date:

Revised September 2020