GJB HEALTH SERVICES, LLC: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name:	PHONE:	DOB:

	❑ EXCHANGE INFORMATION	
	❑ SENDER ❑ RECIPIENT	❑ SENDER ❑ RECIPIENT
Facility Name	GJB Health Services, LLC	
Practitioner(s)	❑ Dr. Gerald Bannasch ❑ Gloria Bannasch, LPC ❑ Tricia Gonzalez, LPC ❑ Tricia Hanford, LPC ❑ Kathleen Mueske, LPC	
Address	711 N Lynndale St, Ste 1A Appleton, WI 54914	
Phone	(920) 560 – 4525	
Fax	(920) 560 - 6618	

PURPOSE FOR NEED OF DISCLOSURE:

❑ Attorney ❑ Doctor / Practitioner ❑ Insurance ❑ Personal

INFORMATION TO BE RELEASED:

For the Following Date(s): From: _____ To _____ (If left blank, the last year of information will be disclosed.)

❑ All Medical Records
❑ Doctor / Progress Notes
❑ Alcohol &/or Other Drug Abuse Treatment
❑ Final Treatment Summary
❑ Psychiatric Evaluation
❑ Therapy Progress Notes
❑ History & Physical Exam
❑ Other Specify:
❑ Intake Assessment
❑ Psychological Reports
❑ Medication List

PATIENT AUTHORIZATION

In compliance with Wisconsin Status, which require special permission to release otherwise privileged information, this Authorization applies to mental health, alcohol and/or drug abuse, developmental disabilities, and HIV test result information, UNLESS EXCLUDED BELOW:

❑ Mental Health ❑ Alcohol and/or Drug Abuse ❑ Developmental Disabilities ❑ HIV Test Results

*I understand that any disclosure made is about by Part 2 of Title 42 of the Code of Federal Regulations (Final Rule) governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may disclose it only in connection with their official duties.

CLIENT RIGHTS

I understand that authorizing the disclosure of this health information is voluntary and I am under no obligation to sign this form and that the covered entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (However, provision of research-related treatment or treatment that is for the sole purpose of creating health information for disclosure to a third party will not be provided without your written authorization.) I understand that I may inspect or receive a copy of the information to be used or disclosed. 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 standards. I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my writing and present my written revocation to Health Information Department. I understand that if I have questions about disclosure of my health information, I can contact the Health Information Management Department at (920) 391-4700.
* If I fail to specify an expired date, event, or condition, this authorization will expire in **ONE YEAR** or _____.

_____ _____

Client Signature / Parent / Guardian / Authorized Representative Date