Northshore Clinic & Consultants, Inc.
W62 N248 Washington Ave., Suite 207
Cedarburg, Wisconsin 53012

OR

_____
_____
_____
_____

Authorization for Release of Information

Patient Name:_____ **D/O/B**_____ **SS#**_____

I Authorize Northshore to: _____ release to _____obtain from (check one or both)

_____

_____

_____

Specific information to be released by Northshore Clinic:

	YES	NO
Medical History & Evaluation	_____	_____
Psychological Evaluation	_____	_____
Psychosocial Assessment	_____	_____
Assessment Findings	_____	_____
Progress Notes	_____	_____
Treatment Planning	_____	_____
Continuing Care Plan	_____	_____
Discharge Summary	_____	_____
Other	_____	_____
_____	_____	_____

Specific information to be released to Northshore Clinic:

	YES	NO
Medical History & Evaluation	_____	_____
Psychological Evaluation	_____	_____
Psychiatric Evaluation	_____	_____
Psychosocial Assessment	_____	_____
Assessment Findings	_____	_____
Treatment Recommendations	_____	_____
Aftercare Plan	_____	_____
Discharge Summary	_____	_____
Other	_____	_____
_____	_____	_____

Purpose for the Disclosure of Information:

A. To assist in the treatment process	Yes	No
B. To facilitate family involvement in treatment	Yes	No
C. Other reasons? (Specify reason if yes is circled)	Yes	No

_____

I hereby hold Northshore Clinic & Consultants, Inc. and it's agent's officers harmless from any acts taken consistent with this authorization. I am also aware that I have the right of access to any information received from or released to Northshore Clinic & Consultants, Inc. I understand that reports released may include psychiatric, alcohol and/or drug abuse records. This consent may be revoked by me in writing at any time, except to the extent that action has been taken in reliance thereon. I also understand that this consent, unless revoked earlier, shall be valid for one year and that a copy of this release will be considered as valid as the original.

_____ Date:_____
Signature of Patient

_____ Date:_____
Signature of Parent, Guardian or Legal Representative/Relationship

_____ Date:_____
Signature of Witness

_____ Date:_____
Signature of Revocation