SOAR
Therapy.Counseling.Care
SERVICES

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## AUTHORIZATION FOR RELEASE OF MENTAL HEALTH PATIENT RECORDS

I, _____ (Date of Birth) _____ do hereby consent to and authorize Soar Services Inc., to _X__ disclose to and/or _X_ obtain from:

_____

_____

_____

information from the records maintained while I was involved with this facility during admission of_____.
The specific information to be disclosed is as follows:

( ) Verbal Progress
( ) Progress Notes
( ) Psychiatric Evaluation and/or Testings, Psychiatric Consultation, and/or Therapy Summaries.
( ) Therapist or Counselor Discharge Summary/Aftercare Plan.
( ) Educational: Grades, Testing Results, Behavioral Observations, Evaluation Results & Recommendations.
( ) Other: _____

The purpose or need for this disclosure is to aid in:

( ) The continuity of care.
( ) Evaluation and/or placement.
( ) Determine eligibility of insurance.
( ) Other:_____

I understand that authorizing the disclosure of this behavioral health service information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided by Federal and State Laws. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient. If I have questions about disclosure of my behavioral health information, I can contact Soar Services Inc.

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 this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Soar Services Inc. Unless otherwise revoked, this authorization will expire (Date, event, or condition) _____(One year maximum). I understand that, upon request, I will be given a copy of this authorization form after signing.

_____ _____
Patient Signature Date

_____
Parent/Legal Guardian/Authorized Representative

☐ Parent ☐Legal Guardian/POA/POHA ☐Authorized Representative

_____
Witness Signature

**NOTE TO RELEASE RECIPIENT:** This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal Regulations (42 CFR - Part II) and Wisconsin Statutes 51.30 and 51.61 prohibit you from making any further disclosure of it without 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.**