Evolve LLC

Authorization for Exchange of Protected Health Information (PHI)

Client Name: _____ DOB: _____

Client Address: _____ Phone: _____

I Authorize To Disclose or Exchange Information To

Evolve LLC	
3416 Association Dr. Appleton, WI 54914	
Phone: (920) 364-9078 Fax: (920) 243-1792	Phone: Fax:

The purpose of this request is for:

_____

The type and amount of information to be used or disclosed is for the following dates.
From: _____ To: _____

Information to be disclosed is the following:
( ) Psychotherapy notes ( )Treatment Plan ( ) Recommendations ( ) Labs

( ) Diagnosis and Prognosis ( ) Verbal exchange of information ( ) Discharge Summary

( ) Growth Charts ( ) medical/medication records ( ) dietitian records/notes

( ) Miscellaneous Reports _____

I understand that I have a right to rescind this authorization at any time. I understand that if I rescind this authorization I must do so in writing and present it to Evolve LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following stated date: If a date is not identified this authorization will expire 12 months from date signed.

I understand that authorizing the disclosure of this health information is voluntary and I need not sign this form in order to assure treatment. I understand that I may inspect or receive a copy of the information to be disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal privacy standards. If I have any questions about disclosure of my health information I can contact Evolve LLC at (920) 364.9078.

_____

Client Signature Date

_____

Parent/ Legal Guardian Date

_____

Agency Witness Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CF part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecure any alcohol or drug abuse patient.

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.