

**Achieve Center**  
**Release of Information**  
2600 Stewart Ave, Suite 38  
Wausau, WI 54401  
(715)845-4900 Fax: (715)845-4970

I, \_\_\_\_\_, (date of birth) \_\_\_\_\_, hereby authorize the Achieve Center to:

disclose and/or  receive information from the following provider/agency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax number: \_\_\_\_\_

Covering the dates from \_\_\_\_\_ to completion of treatment.

This release includes professional communication, both verbal and written, and/or reports produced during treatment with the exception of: \_\_\_\_\_

**Information to be disclosed:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medical history and notes   | <input type="checkbox"/> Consults               | <input type="checkbox"/> Surgical reports      |
| <input type="checkbox"/> Laboratory/Pathology reports  | <input type="checkbox"/> Prescriptions          | <input type="checkbox"/> Hospital records      |
| <input type="checkbox"/> Billing/Financial records   | <input type="checkbox"/> Correspondence         | <input type="checkbox"/> HIV/AIDS test results |
| <input type="checkbox"/> Mental Health Treatment records   | <input type="checkbox"/> Other diagnostic tests | <input type="checkbox"/> X-ray reports         |
| <input type="checkbox"/> School records (including EEN assessment, IEP and reviews, specialist services, standard achievement test, disciplinary concerns/actions) |   |  |
| <input type="checkbox"/> By specific doctor, diagnosis or date range _____   |   | <input type="checkbox"/> Other, specify _____  |

**Purpose for disclosure:**

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Changing Physicians/<br>Providers | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Social Services       |
| <input type="checkbox"/> Insurance    | <input type="checkbox"/> Personal                          | <input type="checkbox"/> Worker's Compensation    | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Legal        |  | <input type="checkbox"/> Law Enforcement          | _____  |

This authorization shall be in force and effect until: \_\_\_\_\_ (1-year maximum) or event or purpose at which time this authorization to use or disclose this protected health information expires.

- ✓ I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to Achieve Center (Attention: Clinic Director, 2600 Stewart Avenue, Suite 38, Wausau, WI 54401).
- ✓ The Achieve Center Privacy Practices outlines privacy issues including revocation of authorization.
- ✓ I understand that Achieve Center will use this authorization for the benefit of the client and will not disclose or request unnecessary or protected information, unless it is a part of a more complete document (i.e., client report).

I understand that I have the right to:

- ✓ Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- ✓ Refuse to sign this authorization.
- ✓ Receive a copy of this authorization containing my signature.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

**A copy of this authorization is as valid as the original.**

\_\_\_\_\_  
Client/Parent/Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client/parent/guardian