Release of Information:

PATIENT INFORMATION:

Name (print)_____DOB: _____

SSN:_____ MA#_____

INFORMATION TO BE RELEASED FROM:

Provider Name:_____ Facility Name: **Marriage & Family Solutions, LLC**

Address: **7818 Big Sky Dr #101, Madison WI 53719** PH: **608-203-6267** FAX: **608-203-6696**

INFORMATION TO BE SENT TO:

Emergency Contact: _____ DOB:_____

Other: _____ DOB:_____

_____ INITIAL HERE IF TWO WAY RELEASE

INFORMATION TO BE RELEASED: (check all that apply)

_____ Appointment Times

_____ Therapist Name

_____Verbal communication regarding:_____

_____ Other: _____

PURPOSE FOR WHICH THE DISCLOSER IS BEING MADE: (check all that apply)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). ***I may revoke this authorization in writing.*** To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I have the right to inspect or receive a copy of the health information to be used or disclosed and this authorization.

Signature:_____ Date:_____

(Patient, guardian, or authorized representative)

THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM THE DATE SIGNED