



Authorization for Use/Disclosure
of Confidential Information

5 Door Recovery
810 W. Olin Avenue, Madison, WI 53715, Phone (608) 827-9170, Fax (608) 630-9078

Client Information:

Last Name First Name MI Phone # Date of Birth

Street Address City State Zip Code

I Authorize:

5 Door Recovery
Name of Person/Organization

810 W. Olin Ave
Street Address

Madison WI 53715
City State Zip Code

To Release Confidential Information To:

Name of Person/Organization

Street Address

City State Zip Code

Information to be Released: (check one)

- ☐ Oral only ☐ Written Only ☐ Oral and Written Communication

Release only the specific information checked:

- ☐ Laboratory Results ☐ Psychiatric Evaluation ☐ Treatment Discharge Summary
☐ Psychological Evaluation ☐ Bio-Psycho-Social History ☐ Progress Notes
☐ Medical History & Exam ☐ Treatment Plan ☐ AODA Assessment /Evaluation
☐ Aftercare Plan
☐ Other, Specify: _____

Reciprocal Release: (Two-way Exchange of Information). I authorize the above information to be released between the above two organizations: (Check one) ☐ YES ☐ NO

Reason for Disclosure of Confidential Information:

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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Expiration Date: This Authorization is valid until _____ (No longer than 12 months).

Your Rights Pertaining to the Authorization:

Right to inspect or copy information Authorized: I understand that I have the right to inspect or copy the confidential information to be released under this Authorization, subject to certain exceptions provided by State and Federal law. Contact the Program Director of you would like to do so.

Right to receive a copy of this Authorization: I understand that if I sign this Authorization, which I am not required to do, that I must receive a signed copy of this Authorization.

Right to refuse to sign this Authorization: I understand that I am under no obligation to sign this Authorization. Treatment, payment, enrollment in a service or eligibility for a service cannot be conditioned upon obtaining this Authorization.

Right to revoke this Authorization: I understand written notification is necessary to revoke this Authorization. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I may contact Catholic Charities at the phone number above. I am aware that my revocation will not be effective as to uses and disclosures of confidential information that the person(s) and or organization(s) named above have already made in reliance of this signed Authorization.

I have reviewed the Authorization. I understand the information presented in this Authorization and by signing this Authorization, I am confirming my approval for release of confidential information.

Signature of Client: _____ **Date:** _____

Signature of Guardian or Power of Attorney (if applicable):

_____ **Date:** _____

If signed by other than the client, indicate relationship to client and legal authority for signature:
