STEPPING STONES COUNSELING CENTER, LLC
Authorization of Disclosure

I hereby request and authorize: Stepping Stones Counseling Center, LLC
219 Ross Ave, Suite 101, Schofield, WI 54476
715-355-4999 (Phone); 1-888-214-5870 (Fax)

_____To disclose to _____Receive From _____Exchange with

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax: _____

The following specific information from my records: Dates of Treatment_____
Type of treatment: _____Mental Health/Counseling _____AODA _____ Other

INFORMATION TO BE RELEASED:

___Verbal Information	___Pychiatric Evaluation	___Discharge Summary/Note
___MD Notes	___Assessment Summary	___Psychological Evaluation
___Physical Exam	___Letters	___Treatment Plan
___Aftercare Plan	___Radiology, Lab Reports	___Questionnaires

Other ("all records" not acceptable) - Please specify

_____

The purpose of such disclosure is:

_____

I understand that I have the right to inspect and receive a copy of this document and the material to be disclosed as required under ss. HFS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this authorization in writing at any time except to the extent that information already released pursuant to this consent cannot be recalled. Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment. I understand that information used/disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

This authorization is effective for sixty (60) days from the date of signing or as specified by the condition state: (no longer than one year) _____

Client signature:_____

Date:_____

Witness signature:_____

Date:_____