Lake Geneva Wellness Clinic

750 Veterans Pkwy, Suite 100
Lake Geneva, WI 53147
Phone: 262-248-7942
Fax: 262-248-1202

Wheatland School Location
6606 368th Ave
Burlington, WI 53105

Erika Fountain, MA, LPC, NCC
Duanne Lafrenz, MSW, LCSW
Laurie Linden, LCSW, SAC
Ashlie Moelter, MS, LPC-IT
Matthew Banas, APSW

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: **FIRST:** _____ **LAST** _____

Other/Previous Name(s): _____ **Date of Birth:** ___/___/_____

I request and authorize the release of healthcare information of the patient named above to:

☐ **INFORMATION TO AND FROM** ☐ **INFORMATION ONLY TO(NOT FROM)**

Name: _____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Phone:_____ **Fax:** _____ **Email:**_____

This request and authorization applies to release of:

☐ **Appointment (date/time) & Billing Information ONLY**

☐ **Mental Health Treatment information relating to the following treatment, condition, or Dates:** _____

☐ **All Healthcare Information**

☐ **Other:**

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ **Yes** **No** ☐

Patient Signature:_____ **Date Signed:**____/_____/_____

Parent/Guardian Signature:_____ **Date Signed:**____/_____/_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED **OR** ON _____/_____/_____

Client Rights: You are NOT required to sign this release. You have the right to a copy of this authorization. You have the right to revoke once signed with a written request to revoke as stated in Lake Geneva Wellness Clinic policy documentation. Redisclosure may occur as defined in federal privacy laws (45CFR Part 164). Drug and alcohol related information is confidential and protected under federal privacy laws (42, CFR part 2) and requires checking the additional box for release.