NORTH SHORE CENTER, L.L.C.
10303 N. PORT WASHINGTON ROAD, SUITE #203
MEQUON, WI 53092
(262) 241-5955 FAX: (262) 241 5926

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

This authorizes North Shore Center, L.L.C. to **disclose** or **receive** from (circle one or both):

_____
(Name of Person, Title and/or Organization)

_____
(Address, City, State, Zip)

The following written verbal information:

NO	YES		NO	YES	
			___	___	DRUG TESTING RESULTS
___	___	TREATMENT SUMMARIES/PLAN	___	___	SOCIAL HISTORY ASSESSMENT
___	___	SUMMARY OF ALL SERVICES	___	___	DIAGNOSIS ONLY
___	___	PROGRESS NOTES	___	___	MEDICATIONS
		FROM _____ TO_____	___	___	ONGOING VERBAL EXCHANGE OF
___	___	ASSESSMENT RESULTS			INFORMATION BETWEEN TWO PARTIES ABOVE
___	___	PSYCHOLOGICAL EVALUATION			
___	___	RECOMMENDATIONS			
___	___	PSYCHIATRIC EVALUATION			
	___	OTHER (specify), _____			

The purpose for the disclosure of the information is:

A. To assist in evaluation and treatment planning:	NO	YES
B. To facilitate family involvement in treatment/evaluation:	NO	YES
C. To coordinate treatment services between providers:	NO	YES
D. Other reasons: (specify reasons if YES is circled)	NO	YES

_____

_____

I understand that my records are protected under the Federal and Specific State confidentiality laws and regulations (initial on or both _____ Chemical Dependency, Fed. Regs. 42CPR, Part 2. _____ Mental Health, SS Chapter 51.30) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it and that, in the event, this consent expires automatically as described below.
THIS RELEASE EXPIRES UPON THE FULFILLMENT OF THE PURPOSE FOR WHICH THIS RELEASE WAS ENACTED AND IN ANY EVENT, SPECIFICALLY EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under as HSS 92.05 and 92.06 of the Wisconsin Administrative Code. These provisions apply to records maintained by an 51.42 agency, including the Ozaukee Department of Community Programs. I further acknowledge that the information to be released was fully explained and this consent is given of my own free will.

DATE: _____ PATIENT SIGNATURE: _____
(Adult or Adolescent 14 years of older)

RESPONSIBLE PARTY/GUARDIAN: _____

This form may be faxed/e-mailed to expedite the process of obtaining pertinent information. If you do not want this form to be faxed, please let us know. FAX/E-MAIL IS AS GOOD AS ORIGINAL.