The Therapy Place of La Crosse, LLC

600 N Third Street, Suite 206
La Crosse, WI 54601

Consent for release of information

Name_____**Date of Birth**_____

I hereby authorize:	Written Communication	yes	no
	Verbal Communication	yes	no
	Reciprocal Communication	yes	no
	*E-mail Communication	yes	no

*note: E-mail is not guaranteed secure

Between:

Name The Therapy Place of La Crosse and:_____

Address 600 N 3rd Street, suite 206, La Crosse, WI 54601 _____

Phone 608 519 5546 _____

Information to be included in this release: (please check all information to be included)

Intake/Assessment____	Progress Notes_____	Discharge summary____	Diagnosis_____
Medical information____	Behavioral Health____	Alcohol/drug_____	Medications_____

Purpose of release: (please check all that apply)

Further medical care____ Personal____ Legal investigation____ Insurance Claim_____ Other____

I understand that by signing this release I give permission for information to be disclosed to/between the above parties and that the information will be handled confidentially in compliance with all applicable federal laws. I am under no legal obligation to sign this release, however under certain circumstances refusing to sign may result in denial of treatment. I have the right to withdraw this release any time by providing a written and dated statement to the Therapy Place of La Crosse indicating such. This will not apply to any records released prior to revocation request. I have discussed any concerns I have regarding releasing this information, including the risks and benefits of such. This release will remain valid for 1 year from date of signature.

Signature of Client_____Date

Signature of parent/guardian:_____Date