



## Authorization for Use or Disclosure of Protected Health Information

### Client Information

<b>Student:</b> _____	<b>Date:</b> _____
<b>Date of Birth:</b> _____	<b>School:</b> Shepherd of the Hills Catholic Schools <b>Teacher:</b> _____
<b>Parent/Guardian Name:</b> _____	<b>Phone:</b> _____ <b>Address:</b> _____

### Recipient Information

I, \_\_\_\_\_, do hereby authorize Into the Woods Wellness, LLC to release a copy of my mental health information to the person or facility below. Name of person/facility to receive mental health information: **Shepherd of the Hills Catholic School**

**Phone:** 920-929-2845

**Address:** W1562 County Road B; Eden, Wisconsin 53019

**Date of Authorization:** \_\_\_/\_\_\_/\_\_\_ **Authorization to expire on** \_\_\_/\_\_\_/\_\_\_ (1 year from start of authorization date)

**Purpose:** This information will be used for the “coordination of care” (unless specifically stated under “Other” below) and for the following purpose(s):

**Description of Information to be Disclosed** (Parent/Guardian/Client should initial each item to be disclosed):

- Educational Evaluation and Program Planning**
- Health Assessment and Planning for Health Care Services and Treatment in School**
- Medical Evaluation and Treatment**
- Other:** \_\_\_\_\_

**Description:** The specific health information to be disclosed consists of the following:

- |  |   |
|--|---|
| <b>Student Academic Records</b>        | <input type="checkbox"/> <b>Student Evaluation</b>          |
| <b>Medical/Health Records</b>          | <input type="checkbox"/> <b>Psychological/Mental Health</b> |
| <b>Education Plans (504 Plans/IEP)</b> | <input type="checkbox"/> <b>Healthcare Plans</b>            |
| <b>Other:</b> _____                    |   |

**Authorization and Signature:**

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless the Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the Provider to be effective.

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by a personal representative:**

a) **Print your name:** \_\_\_\_\_

b) Indicate your relationship to the client and/or reason and legal authority for signing.

**Client is:** \_\_\_ (Minor) \_\_\_ (Disabled)

**Legal authority:** \_\_\_ (Parent) \_\_\_ (Legal guardian) \_\_\_ (Representative of deceased)