Sankofa Behavioral & Community Health
1955 West Broadway Suite 105
Monona, WI 53713
Phone: 608.285.9101
Fax: 608.467.9635

Record #:	
Effective Dates:	

RELEASE OF INFORMATION

(Authorization for the Disclosure and Reciprocal Exchange of Protected Health Information)

Consumer Name *(Last, First, M.I.):*	**DOB:** **Age:**

I, _____ (consumer or guardian), hereby authorize Sankofa Behavioral & Community Health to share the specified Protected Health Information (PHI) with the following agency or individual _____ (agency/individual name).

Address of Agency/Individual:_____

Phone number:_____

Purpose(s) of Information

(Please identify the purpose of release)

☐	☐	☐
☐	☐	☐
Referral	Consultation	Other:
Treatment	Coordination of Services	Other:

Type of Information Release

(Please indicate the type of information you'd like released)

Treatment Progress	☐	Mental Health	☐
Treatment Plan	☐	Alcohol/Drug	☐
Progress Notes	☐	Case Management	☐
Discharge Summary	☐	Crisis	☐
Diagnoses	☐	Trauma	
Medical Information	☐	Other:	
Evaluations	☐	Other:	

My Rights

My right to confidentially has been explained to me. I understand the information to be released, the purpose of the release, and to whom my information will be released. I understand that the information to be disclosed may include information about my mental and physical health and I have the right to inspect the information to be released. I understand that I have the right to revoke this authorization at any time. However, this authorization is valid for 12 months from the effective date, unless I provide written authorization revoking this authorization. I understand that the once SankofaBCH releases the information requested, this agency no longer has control over my privacy with regard to the recipient of the information.

This authorization will automatically expire on _____ (date).

Date	Name (Print)	Signature
	Consumer's:	
	Guardian's:	
	Clinician's:	