Consent to Disclose Confidential Information
Inner Light, LLC
Carolyn P Fuchs, MA, LPC
1724 Laurel Ave, Hudson WI 54016
(P) 715-222-2260
(F)715-386-2858

____
Hereby authorizes the above named agent/Organization to:
_________Disclose To:_________Receive From:_______x__Verbally Exchange
With____x____Facsimile

Name_____Henry Reitka ____
Address___3176 Spruce St Suite A
Little Canada, MN 55117____
DOB_04/21/1966_______________________________ with

Name/Agency:___Greg Meyer____
Address:____
City,State,Zip:____
Telephone Number:_______________________________Fax Number:_____________________
Please check the specific information authorized for release:

______________Intake Assessment
______________Treatment Plan
______________Progress Notes
______________Psychological testing
______________Discharge Summary
______________Notice to Health Care Provider/Physician
_____________Psychiatric Evaluation
_____________Psychiatric Follow-up
_____________Court Reports
_____________Custody Studies
_____________Other Phone Contact

PURPOSE OF DISCLOSURE Coordination of Care________________________________

The authorization will be effective for medical.Treatment records generated to the date of signature until the expiration date or the release is revoked myself. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form. A copy of this authorization is as valid as the original bearing my/guardian(s) signature. I also understand that I may revoke the consent at anytime except to the extent that actions has been taken in reliance on it, and that in any event this consent expires within one year or automatically as follows:
I understand I have the right to inspect and receive a copy of the material to be disclosed, a required under as HFS92.05 and 92.06. Except for the recored of medication and somatic treatment, access to records may be denied under certain circumstances 51.30(4)(d). Records of Substance abuse Services are protected under federal regulations 42 CFR, Part 2.

Specify date, event or condition upon which will expire:________12/13/18________________________________

Signature of Client	Date
Signature of Parent or Guardian	Date
Signature of Witness	Date

Reason Patient is unable to sign:_________Minor__________Deceased______Other

This Facsimile serves a temporary release by request of the client. A permanent one will be filled out at the office.