MIRACLE Counseling

RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION		
Patient's Full Name:		
DOB:	Social Security #:	Sex – ☐ F ☐ M ☑ Other
Home #:	Cell #:	Email:
Mailing Address:		

I authorize Miracle Counseling and Life Coaching LLC to use or disclose information from my mental health records, which may include verval and written information between both parties to:

Name:	
Phone #:	Email:
Mailing Address:	

For the following purpose or need:	The following information is authorized:
Diagnosis and/or treatment planning ☐ YES ☐ NO	Dates of treatment ☐ YES ☐ NO
Educational training ☐ YES ☐ NO	Medical History ☐ YES ☐ NO
Insurance/and or billing purposes ☐ YES ☐ NO	Health evaluations ☐ YES ☐ NO
Other (Specify)	Other (Specify)

This Authorization is subject to revocation at any time and expires upon fulfillment of the purpose for which this consent is given or expiration date: (maximum 180 days). The signee has the right to inspect and receive a copy of the material to be disclosed as required by WI State Statutes.

By signing below, I acknowledge that I have read and understand this Authorization.

Patient's Name		Signature		Date	
Parent		Signature		Date	
Legal Guardian		Signature		Date	
Authorized Person		Signature		Date	
Relationship to Patient		Signature		Date	
Clinician's Name		Signature		Date	