PSYCH MED MANAGEMENT, LLC
Release of Client Information

136 N. Main Street, Ste. 304 Thiensville, WI 53092
13965 W Burleigh Rd., Ste. 103 Brookfield, WI 53005
Mailing Address: PO Box 603, Port Washington, WI 53074
Phone: 262-402-7964 Fax: 262-261-5062

Please Print

Attention Client

- Be sure all lines are filled in before you sign this form
- Be sure the release is in your best interest
- A copy or faxed copy may be used
- The information released cannot be passed to any other agency without your authorization

I authorize and request Psych Med Management, LLC to: (check one)

_____ Release to _____ Obtain from _____ Release to and Obtain from

Agency/Individual

Complete Address Area Code/Phone

The following specific information from the records of:

PRINT Client's Name **Date of Birth**

Specific information to be released **BY** PMM
Release format: __Verbal ___Written ___Fax

___ Client Identification
___ Intake Assessment
___ Drinking/Drug history
___ Psychosocial evaluation
___ Progress Notes
___ Recommendations
___ Diagnosis
___ Discharge summary
___ Other_____

For the treatment time period:
From_____ To_____
List Dates

Specific information to be Released **TO** PMM
Release format: ___Verbal ___Written ___Fax

___ Progress Note
___ Recommendations
___ Legal Information
___ Behavioral information
___ Drinking/Drug history
___ Psychiatric Evaluation
___ Psychological evaluation
___ Discharge summary
___ Other_____
___ Diagnosis
___ IEP
___ School grades
___ School Attendance
___ Medication regime
___ Psychosocial history
___ Treatment history

For the treatment time period:
From _____ To _____
List Dates

This information relates to services for:_____
(Specify, ie: chemical dependency, mental health, development disability, etc.)
Purpose or need for information_____

This authorization expires as of _____(date or specific action) and is not conditional on continuation of treatment at PMM, payment or other benefits due to PMM. This authorization can be revoked at any time prior to this date or action by providing written notice to PMM or provider of records. I understand that any information released prior to revocation cannot be retrieved and PMM will not be held responsible for such. I hereby release PMM and I hold harmless PMM if the recipient re-discloses this information to another party. PMM reserves the right to charge client for copying medical records.

_____ _____ _____ _____
Client Signature (Parent/Legal Guardian) Date Witness Signature