COLLABORATIVE INSIGHTS, LLC
PEGGY BRAAM MS LPC
313 Price Place, Suite 209 | Madison, WI 53711-3262
(608) 556-2388 | peggy@peggybraam.com | www.peggybraam.com

Authorization to Release and Request Confidential Information

Client name ► ______________________ Date of birth ► ____/____/____

I, ______________________ [NAME OF CLIENT], authorize Peggy Braam, MS, LPC to disclose information to and to obtain information from:

Name ▼	Agency ▼		
Address (number and street) ▼	**City/town ▼**	**State ▼**	**Zip ▼**
Telephone ▼	**Fax ▼**	**Email ▼**	

Information to be disclosed/released/requested:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial evaluation
- ☐ Psychological evaluation
- ☐ Psychiatric evaluation
- ☐ Treatment plan or summary
- ☐ Current treatment update
- ☐ Medication management information
- ☐ Presence/Participation in treatment
- ☐ Nursing/Medical information
- ☐ Educational information
- ☐ Discharge/transfer summary
- ☐ Continuing care plan
- ☐ Progress in treatment
- ☐ Demographic information
- ☐ Psychotherapy notes*
- ☐ Other: ______________________
- ☐ Other: ______________________

*Cannot be combined with any other disclosure.

Please note: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with law, including but not limited to verbally, in paper format, or electronically.

The purpose(s) for disclosure/release/request:

- ☐ Billing
- ☐ Coordination of services
- ☐ Treatment planning
- ☐ Transfer of services
- ☐ Other: ______________________

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more strict than HIPAA and provides additional privacy protections.

I understand that this authorization is voluntary and that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and if not revoked sooner in writing, this consent will expire a year from the day signed.

Client signature ► ______________________ Date ► ____/____/____

Therapist signature ► ______________________ Date ► ____/____/____
Peggy Braam, MS, LPC

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in the consent and any other use of this information without the expressed written consent of the client is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2).