VALENTIN CLINIC, S.C.
1220 Dewey Avenue • Wauwatosa WI 53213
414-454-6648

I, (full name) _____, DOB _____ authorize and request that the record custodian of the Valentin Clinic, SC disclose full and complete protected medical information to:

Name of Health Care Provider/Physician/Facility _____
at
Street Address, City, State and Zip Code_____

Phone_____ Fax _____Email_____

I authorize the following to be included under this authorization:

- ☐ All medical records including but not limited to office notes, face sheets, history and physical, consultation notes, progress notes, treatment plans, test/lab results and questionnaires/histories.
- ☐ All billing records including all statements, itemized bills and records of billing to third party payers and payment or denial of benefits.

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and waived. I understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I understand that the information released in response to this authorization may be re-disclosed to other parties. I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. See CFR 164.508.
I understand that the exchange may include verbal, face-to-face, faxed and/or written information. The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. State and Federal regulations prohibit any further disclosure of this information without specific written consent of the person to whom it pertains
I authorize consent for the release of information until the following date or event: .

_____ _____
Patient Signature (patients 14 year of age and older) **Date**

_____ _____
Parent/Guardian Signature **Date**