Child And Adolescent Psychiatry Consulting, LLC
(CAPC)
Horses Treat, LLC

M407 State Highway 97
Marshfield,WI 54449

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Name of Patient: _____ Date of Birth: _____

I authorize CAPC, LLC and HORSES TREAT, LLC to:

disclose to release from exchange with (circle your selection):

(Name of Person and/or Organization) _____
(Address, City, State, Zip) _____

the following information:
_____Name _____Treatment Plans
_____Intake Data _____Impressions _____Discharge Information

for the following purpose(s):
_____Diagnosis
_____Any information necessary for collaboration
_____ Verbal communication
_____ Other:
_____To coordinate services
_____To facilitate treatment planning
_____Other: _____

I understand that my records are protected under Federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance of it and that in any event, this consent expires automatically as described below.
This release expires upon the fulfillment
of the purpose for which this release was enacted and in any event specifically expires 12 months, or sooner if indicated here:_____
I understand that I have a right to inspect and receive a copy of the material to be disclosed as required under HS 92.03(o) and 92.03(3)(d) of the Wisconsin Administrative Code
I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Dated this _____day of _____.20___.

Signature of Patient: _____

Signature of Legal Guardian, if required_____