Insights, Inc
703 N. 8th Street, Suite 202
Sheboygan, Wisconsin 53081

Authorization for Oral Disclosure of Patient Health Information to Family or Friends - HIPAA

I, _____

do hereby consent to authorize *Insights, Inc* to disclose patient health information orally relating to my identity, diagnosis, prognosis or treatment to the individuals listed below.

INDIVIDUALS TO WHOM ORAL DISCLOSURE OF PATIENT HEALTH INFORMATION MAY BE MADE:

1. _____	_____	_____	
Name	Relationship to Patient	Phone	
2. _____	_____	_____	
Name	Relationship to Patient	Phone	
3. _____	_____	_____	
Name	Relationship to Patient	Phone	

DURATION OF AUTHORIZATION / EFFECT OF REVOCATION:

I understand that unless revoked in writing, this authorization will remain in effect for_____years (to be completed by patient) from the date set forth below. If the number of years is left blank, this authorization will expire 2 years from the date signed.

I also understand that this authorization cannot be revoked in part. If I revoke my authorization as to one or more individuals listed, this entire authorization shall be null and void, and I have the option of executing a new authorization form at such time.

_____	_____
Client/Parent/Guardian Signature	Date
_____	_____
Therapist Signature	Date