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

# REQUEST FOR RELEASE OR EXCHANGE OF INFORMATION

I, ________________________________________________________________
(Patient/Parent/Guardian)

hereby consent to the disclosure of the information requested in this document for:

________________________________________________ ______________________
(Myself, My child) (Date of Birth)

TO: Insights, Inc Carol Sherman Haid, MA, LCPC, BCPC

FROM: ____________________________________ ____________________________
(Name of Physician/School/Facility) (Phone Number)

__________________________________________ ____________________________
(Address) (City,State,Zip Code)

Disclosure of the following information: (check all that apply)

( ) Psychological, Psychiatric, Social or other Health Evaluations
( ) School Reports
( ) Medical History and Medications
( ) Hospital/Residential Treatment
( ) Other ____________________________________________________________

Reason for Release ______________________________Authorization Expires ______

________________________________________________ ____________________
(Signature of Patient/Parent/Guardian) (Date)

________________________________________________ ____________________
(Witness) (Date)

Note: This information has been disclosed to you from confidential records which are protected by laws that may prohibit you from making further disclosure of this information without the specific written consent of the patient or legal representative involved.

Rev. 1/2017