Behavioral Health Clinic

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby **Authorize / Decline (please circle one)** the Behavioral Health Clinic of Wausau, LLC to **Release To / Obtain From / Exchange With (please circle one)** the information as indicated via telephone, fax or mail:

Name: _____
(Primary Physician, Teacher, Spouse, etc.)

Address: _____ **Phone #:** _____
(Address for Primary Physician, Teacher, Spouse, etc.)

City/State/Zip: _____ **Fax #:** _____

Patient name: _____ **Date of Birth:** _____

Specific dates to be disclosed: _____ to **ON-GOING**

Specific information to be disclosed (check ALL that apply):

____Intake Information	____Progress Notes	____Aftercare/Referral Plan
____Psychiatric Eval./Consultation	____Diagnosis	____Discharge Summary
____Psychological Eval./Consultation	____Treatment Plan	

Other: **Written and Verbal Communication**

Purpose for such disclosure is: **Continuity of Care**

This authorization is effective for one year from the date of signing or specified as follows: On-going.

SIGNATURE: (patient age 14-17) _____

SIGNATURE: (patient/parent/legal guardian) _____

Date: _____ **Witness:** _____

Redisclosure notice to client: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of client health care records: Unless otherwise authorized by Section 146.82 of the WI Statute, you are prohibited from making any further disclosures of client health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

- **Right to receive copy of this authorization –** You have the right to receive a copy of this authorization.
- **Right to refuse to sign this authorization –** You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  - research-related treatment
  - health plan enrollment or eligibility
  - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- **Right to withdraw this authorization –** You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Medical Records department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim under policy or the policy itself.
- **Right to inspect a copy of the health information to be used or disclosed –** You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by the authorization form. You may arrange to inspect your information or obtain copies of your health information by contacting the Medical Records department.
- **HIV test results –** Your HIV test results may be released without your authorization to persons/organizations that have access under WI law and a list of those persons/organizations is available upon request
- **Mental health treatment records –** You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

☐Copy given to the client/parent/personal representative ☐Client declined a copy