AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MERCYLAND PSYCHIATRY
530 W. Main St., Sun Prairie, WI 53590

Patient Information

_____
Name (last, first, middle initial)

_____
Maiden name or other name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

_____
Birthdate

Health Information

□ Released to □ Exchanged with

_____
Name of individual(s) / Organization

_____
Name of individual(s) / Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Telephone Number Fax Number

Delivery Preference
□ Mail
□ Pick-up Date: _____
Who will pick up the records? _____

For Provider Use:
Diagnosis: _____

Provider: _____ Department: _____

Check to send last results of the following:

□ Provider Notes: _____
□ Labs: _____
□ Medical Imaging Report □ Medical Imaging CD
□ Pathology: _____
Cardiology Studies (EKG/Echo/Stress Test): _____
Specify other notes: _____

I authorize the following facility to disclose health information identified in the next section.

Specify type of health information to be disclosed:

□ All health records (last 2 years)	□ Progress Notes	□ Discharge Summary	□ Medications
□ History & Physical	□ Therapy Notes	□ Outpatient Report	□ Condition Updates
□ Lab Reports	□ Vision Records	□ Immunization Record	
□ Medical Imaging:	□ Other (specify): _____		
□ CD □ Reports □ Echo	_____		

Health information protected by federal confidentiality rules (42 CFR part 2):

□ BH Diagnostics	□ BH Mental status exam	□ BH Attendance	□ Psychological testing
□ Drug/alcohol history	□ BH Physical exam	□ Psychiatric history	□ BH Medication management
□ BH Treatment summary or plan	□ BH Initial intake / assessment	□ BH Discharge/summary transfer	□ Psychotherapy notes
□ AODA	□ Hepatitis B	□ AIDS	□ Sickle cell anemia
□ HIV infection	□ TB	□ STD	

□ Other: _____

Dates of health information to be disclosed and/or chronic condition: _____

_____

Disclosure may be in the form of: □ Photocopies □ Fax □ Verbal communication □ Inspection □ Written correspondence

Purpose of need for disclosure:

□ Continuity of care	□ Personal use	□ Second opinion	□ Payment of insurance claim
□ Application for insurance	□ Legal investigation	□ Disability determination	□

□ Other: _____

I understand that this authorization may be revoked by me at anytime (with the exception that Mercyland Psychiatry has already acted in reliance on it) by written notice. I have the right to inspect and receive a copy of the material to be disclosed and receive a copy of the informed consent. This consent will remain in effect until the above request is processed or unless otherwise specified. When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

Prohibition of Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2 and Wisconsin Statute 51.30). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand I may inspect and receive a copy of the disclosed information.

I understand a photocopy of this consent is as valid as the original. This consent is valid for a period of one (1) year.

_____ _____

Patient Signature **Date** **Time**

If signed by person other than the patient, complete the following:

Patient is: □ a minor □ incompetent □ disabled □ deceased

Legal authority: □ parent of minor* □ legal guardian □ next of kin of deceased □ Power of Attorney for HealthCare (attach POA document)

* For minors: Are you the parent of the child? □ yes □ no If so, have you ever been denied custody of this child? □ yes □ no

_____ _____

Signature of person legally authorized to sign **Date** **Time**