7633 Ganser Way, Suite 204
Madison WI, 53719
Phone: (608) 829-1800
Fax: (608) 829-1885

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Name:			Date of Birth:
Address:			Phone:
City:	State:	Zip:	Fax:

I hereby authorize and request **Mental Health Solutions, S.C.** to:

☐ Release Information To: ☐ Obtain Information From: ☐ Exchange Information With:

Person/Organization:			
Address:			Phone:
City:	State:	Zip:	Fax:

Information to be Disclosed:

☐ All Mental Health Records ☐ Psychotherapy Notes ☐ Admission/Discharge Summary

☐ Psychiatric Evaluation ☐ Alcohol and Drug Evaluation / Treatment ☐ Laboratory Results

☐ Psychological Testing ☐ Medication History ☐ _____

Purpose of Disclosure:

☐ Coordination of Care ☐ Disability Determination ☐ Insurance

☐ Psychiatric Treatment ☐ Confirmation of Diagnosis ☐ Legal

☐ Psychological Treatment ☐ Request of Client ☐ _____

I understand that this authorization is in effect for one year or until: _____
unless otherwise revoked through written notice.

By signing this authorization, I acknowledge that I have read the reverse side and I release the above institution(s) and/or person(s) from legal responsibilities or liability that may arise from this act.

Signature of Client (14 and older):_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PROTECTED HEALTH INFORMATION

Mental Health Solutions, S.C. honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign

You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, Mental Health Solutions, S.C. providers may not refuse to provide you treatment or other health care service if you refuse to sign this form.

Revocation

You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or Organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to Mental Health Solutions, 7633 Ganser Way, Suite 204, Madison, WI 53719.

Re-release

If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your permission.

Right to Inspect

You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the medical records staff of Mental Health Solutions.

Copying Fees

You and/or the organization(s) to whom your medical information is release may be charged a reasonable and customary fee for copying your medical records.

Signatures

Generally, all patients 18 years of age or older must sign for the release of their records. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply:

a) The patient is incompetent
b) The patient is disabled or cannot sign the form
c) The patient is deceased, then the surviving spouse or legal representative must sign authorizations releasing records of the deceased patient

Patients under the age of 18 must sign for release of their medical records when:

a) The patient is 14 years of age or older **and**
b) The records involve treatment for mental illness, alcoholism, or drug dependence