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

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION – VERBAL

Patient Information

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

I hereby authorize and request **Mental Health Solutions, S.C.** to
communicate and receive information for the purpose of coordinating care regarding:

☐ All Billing Information ☐ Appointments – Schedule/Cancel ☐ Appointments - Verify
☐ Prescription/Pharmacy Request ☐ Treatment Update ☐ Other: ________________

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

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

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. In accordance with the conditions listed above, I authorize the disclosure or exchange of my protected health information. This authorization includes disclosure or exchange of information regarding mental health or illness, developmental disabilities, substance use disorders, genetic testing, sexually transmitted illnesses, AIDS or AIDS-related illness, and/or HIV test results unless I limit the disclosure to exclude the following:

____

Signature of Client (14 and older):____ Date:_______________________________

Printed Name of Authorized Person:____

Signature of Authorized Person:____ Date:_______________________________

If signed by a person other than the patient, stated authority to do so:

☐ Legal Authority ☐ Legal Guardian ☐ Next of Kin ☐ Parent of Minor ☐ Power of Attorney

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. However, there are many situations in which this general rule does not apply:

a) The patient is incompetent
b) The patient is disabled or incapacitated and 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

For patients under age 18, it is preferred that both the patient **and** a parent/guardian sign for the release of the records indicated below. However, patients under the age of 18 may sign alone for release of their medical records when:

a) The patient is 12 years of age or older **and** the records involve treatment for alcohol or drug use
b) The patient is 14 years of age or older **and** the records involve treatment for mental health
c) The patient is 14 years of age or older **and** the records involve testing for HIV