Child and Adolescent Psychiatry Consulting DBA

EMPOWER

MENTAL HEALTH CLINIC

□ Empowermhc.com □ 2001 S Central Ave Ste. A Marshfield, WI 54449 □ (715)384-2818 □

Authorization for Release of Confidential Information:

I, _____ , _____ hereby authorize
(Client's name) (DOB)

CAPC/Empower Mental Health Clinic staff and/or _____ to

☒ Release records of my treatment to:
☒ Obtain records from:

Name (agency/facility/physician): _____

Street address: _____

City: _____ State: WI Zip: _____ Phone #: _____
Fax # : _____

Information from the medical and/or psychiatric records relating to the identity, diagnosis, prognosis, or treatment on the above named patient. The specific type of information to be disclosed includes copies of:

- ☐ Psychiatric assessment/treatment
- ☐ Psychiatric/clinical consultations
- ☐ Psychiatric/AODA hospitalizations
- ☐ Psychiatric/AODA discharge summaries
- ☐ Psychiatric reports/testing
- ☐ Psychological Evaluation
- ☐ Intake/Discharge Summary
- ☐ Clinical progress notes
- ☐ Treatment Plan
- ☐ Medical History
- ☐ School records
- ☐ Verbal/phone contact
- ☐ Dates of Contact
- ☐ Alcohol/Drug Assessment
- ☐ AODA Assessment Summary
- ☐ Alcohol and drug history and treatment
- ☐ Health care info. related to mental health/AODA
- ☐ Other:

The purpose for this disclosure is to:

- ☐ Facilitate treatment
- ☐ Coordinate services
- ☐ Transfer care
- ☐ Other

I understand that this consent is revocable except to the extent that action has been taken in reliance there on, and that consent will remain in force for (1) year in order to effectuate the purposes for which it is given. Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole, or other proceedings under which I am mandated into treatment (42 CFR Part 2.35)

This information has been disclosed from records whose confidentiality is provided by federal and Wisconsin law (~51.30 WI Stats) Federal regulations (42CFR part 2) and Wisconsin law (~51.39) prohibits redisclosure without the specific written consent of the person who it pertains, or as otherwise permitted by such regulations and statute. A general authorization for release of medical or other information is not sufficient for this purpose. Federal laws and regulations cited here provide that any person who violates these provisions shall not be fined more than $500 in the case of the first offense, and not more than $5,000 in the case of any subsequent offense.
By signing this, you specifically authorize the use and disclosure of the information selected above. You understand that a photocopy of this consent is as valid as
the original. You acknowledge that you have reviewed and understand this authorization form, including the notices on the back of this form.

_____ _____
(Client signature/ Date) (Witness signature/ Date)
Required for age 12 & over for AODA, age 14 & over for Mental Health

(Parent or Legal Guardian signature/ Date) State relationship: Parent or Guardian

_____ _____

REDISCLOSURE NOTICE: I understand that if the person(s) and/or organization(s) listed on page 1 are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and my health information may be redisclosed by such person(s) and/or organization(s) without obtaining my authorization.

DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written consent 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 a copy of this authorization** – I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

- **Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed on page 1 may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding:
  - Research-related treatment
  - 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** – I understand that if I want to cancel this authorization, I must do so in writing and present the cancellation document to Child & Adolescent Psychiatry Consulting LLC. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed on page 1 have made prior to receipt of my cancellation request.

- **Right to inspect or copy the health information to be used or disclosed** – I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I understand that a fee may be charged for copying services. I may arrange to inspect my health information or obtain copies of my health information by contacting the Administrative Assistant at Behrend Psychology Consultants.

- **HIV test results** – I understand my HIV test results may be released without authorization to persons/organizations that have access under Wisconsin law and a list of those persons/ organizations is available.

- **Mental health treatment records** – I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.