Pathway to Wellness
Community Clinic

560 4th St. Prairie du Sac, WI 53578 Phone (608) 643-3663 Fax (608) 370-8177

AUTHORIZATION FOR DISCLOSURE OR EXCHANGE OF CONFIDENTIAL MEDICAL RECORDS

PHYSICIAN OR THERAPIST NAME:

_____

By checking both of the box below, you are exchanging information

Release To: ____ Receive From: ____

Patient Information

Name: _____

Address: _____

City: _____ State: _____

Zip: _____ DOB: _____

Primary Phone: _____

Organization Name: _____

(i.e. ,Insurance, Physician, Lawyer, Family, other)

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

Type or extent of information to be disclosed or exchanged:

A) _____ Specific Records as follows:
_____ Intake Assessment _____ Psychiatric Reports _____ Treatment Records _____Educational Records
_____AODA Assessment/Treatment Records _____ Evaluation Reports ____ Psychological Testing
Specific records pertaining to: _____

B) _____ Complete Copy of all Records ____ Including Psychotherapy Notes ____ Not Including Psychotherapy Notes

C) _____**VERBAL** communication regarding my ongoing treatment and/or treatment plan.

Purpose for Disclosure or Exchange: (Check all applicable categories.)

____ further medical care ___vocational rehabilitation ___ payment of insurance claim ___ coordination of treatment
____ psychotherapeutic treatment ___legal investigation ___psychological evaluation ___disability determination
____ coordination with school ___ Other_____

This authorization will remain in effect for one year and will include future records generated throughout the year unless you specify below that this authorization is effective for a specific time period. (See reverse side for more information.)

____ Specific time period: _____
____ **DO NOT** include future records

In accordance with the specifications listed above, I authorize the disclosure or exchange of my records pertaining to alcohol and drug treatment, AIDS or AIDS related illness, and/or HIV test results, pertaining to mental health records, alcohol and drug treatment, AIDS or AIDS related illness, and/or HIV test results.

I hereby consent to and authorize the release of information as described on this form. I may also receive a copy of this consent form. The client or person authorized has a right to inspect and, upon payment of usual fee, receive a copy of the material to be disclosed. I understand that I am under no obligation to sign this form and that treatment will not be denied if I refuse to sign this authorization. WI statutes 51.30 and 252.15 confidentiality of Alcohol and Drug Abuse Patient Records, 42C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"),45 C.F.R. pts 160 and 164 require patient authorization to disclose health information for payment purposes. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining my authorization. The patient has the right to withdraw this authorization for disclosure or exchange at any time.

Patient Signature: _____

Parent or Guardian Signature: _____

Patient is: ___ Minor ____ Incompetent ____ Incapacitated _____ Deceased

Legal Authority: ____ Legal Guardian ___Parent of Minor ___ Spouse of Deceased

_____ HealthCare Agent: _____

_____ Personal Representative of Decreased _____ Other _____

_____ _____

Witness Signature **Date**

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Pathway to Wellness Community Clinic, LLC 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, Pathway to Wellness Community Clinic, LLC 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 Pathway to Wellness Community Clinic, LLC 560 4th St. Prairie du Sac, WI 53578

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 lost its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior 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 Pathway to Wellness Community Clinic, LLC (608) 643-3663.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. 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. For more information regarding who is authorized to sign this form, please contact Pathway to Wellness Community Clinic, LLC at (608) 643-3663 with any questions.