Authorization-Release of Information

Find Balance, Build Your Strengths, and Achieve Mental Well-Being.

Patient Information

Name - Last, First, MI

Former/Maiden Name | Date of Birth

Street Address, City, State, & Zip Code

Place a check in front of your preferred method of communication :

☐ Phone Number ☐ Cell Phone Number

I Request and Authorize Weston Psychiatric to:

☐ Disclose to ☐ Receive from ☐ Exchange with

Name (i.e. Health Facility, Physician…)

Relationship to Patient/Class of Treatment Provider

Street Address, City, State, & Zip Code

Phone # | Fax #

The Specific Type(s) of Information I Authorize to be Either Disclosed, Released, or Exchange:

Check applicable conditions:

☐ Mental Health Treatment ☐ Drug or Alcohol Treatment/Evaluation ☐ HIV Test Results

☐ Other (Specify):

Dates Authorized for Release:

Health Information I Authorize to be Either Disclosed, Released, or Exchange:

(Check all applicable categories)

☐ Assessment Summary	☐ Mental Health Summary Letter	☐ Psychological Evaluation
☐ Psychiatry Evaluation	☐ Physical Exam	☐ Physician Notes
☐ Discharge Summary	☐ Progress Notes	☐ Treatment Plan
☐ Aftercare Plan	☐ Medication List	☐ Lab Reports
☐ Letter/Correspondence	☐ Verbal Information	☐ Questionaires
☐ Other (Specify):		

Purpose for Need of Disclosure, Release, or Exchanged:

☐ Continued Medical Care ☐ Legal ☐ Personal

☐ Insurance ☐ Other (Specify):

HIPPA DISCLOSURE STATEMENT

Your Rights With Respect to This Authorization

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Weston Psychiatric 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: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the below addressee. I am aware that my withdrawal will not be effective until received by Weston Psychiatric and will not be effective regarding the uses and/or disclosures of my health information that Weston Psychiatric has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Unless otherwise revoked, this **authorization will expire on the following date or event:** __________ **If I fail to specify an expiration date, this authorization will expire in 12 months.**

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Department.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

By signing this authorization, I am confirming that it accurately reflects my wishes.

PATIENT: ____ DATE:_________________

LEGAL REPRESENTATIVE:____DATE:_________________

Printed Name of Legal Representation: ____

If signed by someone other than the patient, state relationship: __________________________________

Please return this form via mail or E-fax to:

Weston Psychiatric
5703 Memorial Ct,
Weston, Wisconsin 54476
E-Fax: 774-209-4285

Any Questions? Call 715-204-9808