CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

I, ______________________________ born on _________________, hereby authorize Brotoloc North to disclose to/ receive information from:

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the following information from my records (check each item to be released):

☐ Resident Intake Forms	☐ Court Records	☐ Staffing Reports
☐ Medical Histories & Physicals	☐ Discharge Summaries	☐ Psychological Reports
☐ Progress Notes	☐ Psychiatric Reports	☐ Treatment Plans
☐ Social Histories	☐ Educational Records	☐ Other: ___________________

Time period for which records are requested: ____

Extent and purpose of this disclosure: ____

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in statute. I understand that authorizing the disclosure of this behavioral health service information is voluntary. I can refuse to sign this authorization. I understand that I have a right to inspect and/or receive a copy of the materials to be disclosed and a copy of this consent form, unless this right is denied by the medical director of the facility during my treatment. My access to information concerning medication or its administration and to somatic treatment may not be denied (51.30 Wis. Stats). I also understand that I may revoke this consent at any time through a written request, except to the extent that action has been taken in reliance on it. (e.g. the provision of treatment upon consent to disclosure to a third party payer), and that in any event this disclosure expires automatically as described below.

REDISCLOSURE NOTICE TO PATIENT: I understand that if the person(s) and/or organization(s) listed above are not health care providers, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards if such person(s) and/or organization(s) re-disclose my health information.

DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS: Unless otherwise 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.

DISCLOSER 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 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.

Rights:

- 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.
- 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 above 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
    - Health plan enrollment or eligibility
    - 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. 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 authorization(s) listed above have made prior to the receipt of my cancellation form. I understand that 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.
- Right to inspect a copy of 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.
- 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.

Specification of the date, event, or condition upon which this consent expires:

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As evidenced by my signature, I hereby authorize disclosure of records to the persons or agencies specified above.

Signature of the Individual Who is the Subject of the Record	Date:
Signature of Other Person Legally Authorized to Consent to Disclosure/Relationship /	Date:

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected under State and Federal law. These regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of information is not sufficient for this purpose.