Pauquette Center for Psychological Services

Authorization to Use and/or Release Protected Health Information

#1. I, _____ (_____) , authorize:
Client Name Date of Birth

#2. Pauquette Center for Psychological Services 2901 Hunters Trl., PO Box 301, Portage, WI 53901
Phone: 608-742-5518 EXT. 730 (for records) Fax: 608-268-9780 Email: info@pauquette.com

#3. □ To release to:
□ To Obtain from:
□ To Exchange with:

#4. Name : _____Phone:_____Fax:_____
Facility:_____
Address: _____, City: _____, State:_____, ZIP: _____

#5. Protected Health Information to be disclosed – verbally and/or in writing:

Records:
□ Psychiatry Records
□ Intake Summary
□ Treatment Plans
□ Discharge Report
□ Medication and Allergy List
□ Psychological Evaluation - Summary and Recommendations
□ Case Notes
□ Diagnosis/Problem list
□ Assessment - Summary and Recommendations
□ Criminal Complaint and/or DPA (Deferred Prosecution Agreement)
□ Summary of Medical Record Chart (includes discharge summaries, consultations, emergency room records, outpatient Notes, pathology reports and clinic summaries)
□ Other: _____

Verbal:
□ Verbal Info re: Treatment
□ Verbal Info re: Scheduling / Appointments
□ Verbal info re: Billing / Payment
□ Verbal info re: Transportation
□ Other: _____

#6. Purpose or need for disclosing the client's Protected Health Information:
□ Continuity of Care
□ Treatment
□ Communicate Scheduling / Appointment Information
□ Communicate Billing / Payment Information
□ Compliance with requirements of: _____
□ Other: _____

#7. Time period, from which, the Protected Health Information is being requested:
□ Most recent 2 years
□ Specific dates:(mm/dd/yyyy to mm/dd/yyyy)_____to_____

#8. Special Consent: This authorization permits the disclosure of information regarding: mental illness, developmental disabilities, alcohol/drug treatment, and HIV/AIDS/STD test results/treatment, unless I specify, on the line below, the information that I do not want to be disclosed: _____

#9. Expiration:
This authorization will expire:
□ 1 year from the date of your signature.
□ 2 years from the date of your signature.
□ Other specified date:_____

#10. Note:
- ❖ This authorization allows the specified PHI to be disclosed verbally or by: mail, fax, encrypted email, or text (for appointment reminders).
- ❖ This authorization allows the specified PHI to be disclosed from the signature date forward, until the date of expiration.

ADDITIONAL INFORMATION REGARDING THIS AUTHORIZATION

Right to refuse to sign this authorization: You are under no obligation to sign this form. Except as permitted under applicable law, Pauquette providers may not refuse to provide you treatment or other health care services if you refuse to sign this authorization.

Right to revoke this authorization: You have the right to revoke this authorization, in writing, at any time before it ends. However, revoking this authorization will not affect any disclosures of your health information that were made prior to receiving your written revocation request. Your revocation must be made, in writing, and addressed to: Pauquette Center, Attn: Privacy Officer, 2901 Hunters Trail, Portage, WI 53901.

Right to receive a copy of this authorization: You have the right to receive a copy of this authorization after signing it.

Right to inspect and/or copy: You have the right to inspect and/or receive a copy of the health information that you have authorized to be disclosed by this authorization; however, please know that certain exceptions under federal and state law may apply. To do so you must submit your request, in writing, using the clinic's "*Request for Access to Health Information*" form. You may be charged the designated fee for copies of your health records.

Disclosure of patient status: Communications resulting from this authorization will reveal that you receive services at the Pauquette Center for Psychological Services.

Re-disclosure notice to patient: If the organization(s) and/or person(s) authorized by this form to receive your health information are not health care providers or entities or persons who must follow the federal health privacy laws, the health information they receive as a result of your authorization may no longer be protected by the federal health privacy laws, and those organization(s) and/or person(s) may be permitted to re-disclose your health information without your prior permission.

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 this information without the specific written consent of the person who is the subject of such information or as otherwise permitted by these regulations. A general authorization or release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authority to sign:

- Adults (age 18 or older) can sign this authorization to disclose PHI about themselves.
- Legal representatives signing this authorization on behalf of a client must state their relationship to the client, and have available proof of legal authority to act on the client's behalf.
- A parent or legal representative can sign this authorization for a minor child (under age 18) regarding mental health information.
- Minors age 14 – 17 can sign this authorization regarding mental health information about themselves.
- Minors age 12 – 17 can sign this authorization for AODA information about themselves. A parent or legal representative cannot access or authorize disclosure of AODA information about a minor child age 12-17 without the consent of the minor.

Internal transfer of authorization: This authorization may be used by the Pauquette Center for Psychological Services' owned or managed programs upon transfer of your care to them.

Validity of copy: A photocopy or facsimile copy of this authorization shall be as effective and valid as the original document.

I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes regarding the use/disclosure of my Protected Health Information.

_____ _____

Signature of Client Date

(AODA Tx: minor age 12-17 must sign)

(MH Tx: either minor age 14-17 or Parent/Legal Representative may authorize release of records)

_____

Printed Name of Client

_____ _____

Signature of Parent or Legal Representative Date

_____ _____

Printed Name of Parent or Legal Representative Relationship to client