MADISON PSYCHIATRIC ASSOCIATES

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Name:			Date of Birth:
Address:			Phone:
City:	State:	Zip:	Fax:

I hereby authorize and request **Madison Psychiatric Associates, Ltd.** to: (please select one)

☐ Release Information To*: ☐ Obtain Information From: ☐ Exchange Information With:

☐ *Check here if you are requesting we send paper records. Unless specified, MPA will only send the last year of medical records. If you would like more than that sent, please indicate dates here: ___/___/____ to ___/___/____.

☐ I authorize records to be sent via facsimile. (Optional) (Optional)

Person/Organization: Please provide at least one contact method.			
Address:			Phone:
City:	State:	Zip:	Fax:

Information to be Disclosed: Please check at least one box

☐ All Mental Health Records ☐ All Medical Records ☐ Admission/Discharge Summary
☐ Psychiatric Evaluation ☐ Alcohol and Drug Evaluation / Treatment ☐ Laboratory Results
☐ Psychological Testing ☐ Medication History ☐ _____

Purpose of Disclosure: Please check at least one box

☐ Coordination of Care ☐ Disability Determination ☐ Insurance
☐ Psychiatric Treatment ☐ Confirmation of Diagnosis ☐ Legal
☐ Psychological Treatment ☐ Request of Client ☐ _____

I understand that this authorization is in effect for two years or until: _____ unless otherwise revoked through written notice.

By signing this authorization, I acknowledge that I have read the reverse side and I release the above institution(s) and/or person(s) from legal responsibilities or liability that may arise from this act.

Signature of Client: _____ Date: _____

Printed Name of Authorized Person: _____

Signature of Authorized Person: _____ Date: _____

If signed by the person other than client, stated authority to do so below. Please select one option below.

___Legal Authority ___Legal Guardian ___Parent of Minor ___Next of Kin ___Power of Attorney

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Madison Psychiatric Associates, Ltd., honor 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, Madison Psychiatric Associates, Ltd., may not refuse to provide you treatment or other health care services if you refuse to sign this form. However, if you refuse to release this information by signing the form, it could result in a failure, for example, to properly coordinate your treatment with other health care providers such as your psychiatrist or primary physician, thus making your treatment less effective. Depending on the specific situation, other potentially harmful effects could occur.

Revocation: you have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization 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: Madison Psychiatric Associates, 5534 Medical Circle, Madison, WI 53719-1298.

Re-release: If the person(s) and/or organization 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 lose 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 your clinician or the office of Madison Psychiatric Associates, Ltd. In accordance with Wisconsin Stature 51.30 [Patient Access s.51.30(4)(d)3], inspection of a record shall be done with a clinician present.

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 may be charged 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. I you are under the age of 18, your parent or guardian must sign this form for you. There are, however, many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact Madison Psychiatric Associates, Ltd., at 608-274-0355.