Appendix I

SAMPLE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize the disclosure, release, re-release, and exchange of the records and information specified below concerning

NAME_____ whose date of birth is_____ between the following organizations:

Aging & Disability Resource Center
of Portage County
_____
1519 Water Street
Stevens Point, WI 54481

AND

Ministry Medical Group – Rice Medical Center/
St. Michael's Hospital/Clinics
Attention:_____
824 Illinois Avenue
Stevens Point, WI 54481

TYPE OF INFORMATION TO BE RELEASED: _____ Verbal _____ Written

INFORMATION TO BE RELEASED:

___ Intake/Initial Assessment
___ Psychiatric/Psychological Evaluations
___ Social History
___ Treatment Plan/Reviews
___ Basic Identifying Information
___ Staffing/Progress Notes
___ Medical Evaluations/ H & P / Records
___ Education Evaluations/Records
___ Income Maintenance Records
___ Other (Specify): _____
___ HIV (AIDS)
___ Laboratory Reports
___ Medications
___ Discharge Summary

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Disability Determination (SSI/SSDI)
___ Benefit Applications (FS/Medicaid)
___ Other (Specify):_____
___ Insurance/Payment Concern
___ Legal Investigation or Action
___ Medical Care
___ Personal

I understand that if the person and/or agency listed above is not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further re-disclosure without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

I understand that I have the right to inspect or have a copy of the confidential information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact the staff providing/coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person and or agency listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the completion of active services with PORTAGE COUNTY unless a specific date is entered here _____ or unless a written notice of revocation is submitted.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original.

PRINT NAME: _____

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

Signature is that of the: ___ Client/Patient ___ Parent of Minor ___ Legal Guardian ___ Client/Patient's Representative

WITNESS: _____