

MILWAUKEE PSYCHIATRIC PHYSICIANS CHARTERED
12760 W. North Ave., Brookfield, WI 53005
CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: ____/____/____
Address: _____ City/State/Zip: _____
Phone Number: _____ Last 4 digits of patients SSN: _____

I authorize the information to be disclosed by:

RELEASE BY: Name: _____ Phone #: _____ FAX #: _____
Address: _____ City/State/Zip _____

I authorize the information to be disclosed to:

RELEASE TO: Name: _____ Phone #: _____ FAX #: _____
Address: _____ City/State/Zip _____

____ Information to be shared by both of the above parties.

The purpose of disclosure: _____ Further Medical Care _____ Insurance Eligibility/Benefits _____ Legal Investigation
_____ Disability Determination _____ Personal Reasons _____ Forms Completion _____ Certified Records
Other: _____

TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED: (Check all that apply)

____ Entire Medical Record (Please note: If your request is for continued medical care, only a General Abstract of your medical record will be provided. A description of a General Abstract is Discharge Summary, H&P, Consults, etc.)
____ Only these specific documents: _____
____ Only Information Related to Specific Condition or Treatment for: _____
____ Records from a specific date: ____/____/____
____ Records from a specific time period: From: ____/____/____ TO: ____/____/____
Other (Please List): _____

Released via: ____ US Mail ____ FAX ____ Electronic ____ Personal Pick Up ____ Pick Up by: _____
____ Mutual Progress updates – written or verbal.

This Authorization is effective until: ____/____/____ (If no date is entered the authorization will be valid for one (1) year from the date of signature) and includes records that were created or existed on or before the date this authorization was signed.

____ This includes records that are created after the date this authorization was signed, up until the expiration date. ____ (Initials)

The following information is important for you to read.

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the MPPC Health Information Department. I understand that the revocation will not apply to information that has already been released.
- I understand that I have the right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of medical records that I receive.
- I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearing houses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- A photocopy or fax of this authorization shall be considered as valid as the original.

_____/_____/____ : ____ AM/PM
Signature of Patient or Legal Representative Date Time

If signed by someone other than patient, state legal authority:

- ____ Legal guardian of the patient (proof of guardianship required)
- ____ Parent of the above named minor child and I represent that I have not been denied periods of physical placement with my child by a court.
- ____ The legal representative of a deceased patient (proof required)
- ____ The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required)

Internal Use Information

Witness: _____ Date: ____/____/____ Time: ____:____ AM/PM
Completed by: _____ Date: ____/____/____ Time: ____:____ AM/PM