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