Release of Information Authorization

Patients Name _____ **DOB** _____ **Phone** _____

Address _____ **City, State, ZIP Code** _____

Authorizes: *The Caring Tree 2804 Rib Mountain Dr, Suite D., Wausau WI 54403, 715-301-0667 Fax: 715-870-2267*

To release written and verbal information to, AND to receive written and verbal information from:

Name (Person, Organization, other): _____ **Attention** _____

Address _____ **City, State, Zip** _____

Phone _____ **Fax** _____ **Email:** _____

I authorize *The Caring Tree – Children's Counseling Center* **to release and/or obtain the following written and/or verbal information/records, unless otherwise specified:** Medical treatment information, voicemail, appointment verification, Mental Health Assessment and treatment notes, alcohol and other drug therapy, neuropsychology notes, to obtain copies or authorize release of my medical records which may include authorizing release of medical records to other facilities on my behalf, educational testing and/or information, school records, billing information about my account which may include health information, and other specific information as follows: _____

MINOR special medical record release: I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or anyone else.

Medical records to be disclosed:

___ Outpatient alcohol or other drug dependency care *(12 years or older) (parent may also be required to sign below)*
___ Rape or sexual assault/abuse *(12 years or older) (parent may also be required to sign below)*
___ Outpatient mental health care *(14 years or older) (parent may also be required to sign below)*
___ Inpatient mental health care *(14 years or older).* ___ HIV/AIDS test results *(14 years or older).*
___ Neuropsychology notes *(14 years or older) (parent may also be required to sign below)*
___ Sexually transmitted disease *(17 years or younger)* __ Pregnancy related care or care of newborn *(17 years or younger).* ___ Pregnancy test *(17 years or younger) (parent may also be required to sign below)*
___ Birth control pills or devices *(17 years or younger) (parent may also be required to sign below)*
___ Family member who works at *The Caring Tree* can access my electronic medical record, including but not limited to information above *(parent may also be required to sign below)*

Patient signature _____ **Date** _____

Reason for the release: (mark all that apply)

_X_ Continuing healthcare needs	___ Personal	_X_ Follow up
___ Disability	___ Financial assistance	___ Other, specify: _____
_X_ Transfer of care	___ Pre-employment/medical eval	
_X_ Care Coordination/Case Mgmt	___ Billing, collection or claims	
___ Second opinion/referral	___ Legal/court proceeding	

EXPIRATION. This authorization will remain in effect until: _X_ You cancel this authorization in writing.

By signing this, you specifically authorized to use and disclosure of information selected above. You acknowledge that you have reviewed and understand this authorization form, including the notices below.

Patient Signature/Patients Legal Representative _____ **Date** _____

Relationship to patient _____ **Phone number** _____

Fax the completed authorization to 715-870-2267. Email: taylor@caringtree.us

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 it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.* ***Your rights with respect to this authorization****-Right to receive a copy of this authorization you have the right to receive a copy of this authorization.* ***Right to refuse to sign this authorization****-you have the right to refuse to sign this authorization. The organization listed above may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on your decision to sign this authorization except regarding research – related treatment, or health plan enrollment or eligibility, or the provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a third-party.* ***Right to withdraw this authorization*** *you understand that you must cancel this authorization in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the organization listed above had made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.* ***Right to inspect a copy of the health information to be used or disclosed-****you understand that you have the right to inspect or copy (maybe provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.* ***Mental health treatment records*** *you have the right to inspect and receive a copy of your mental health treatment records to the extent required by DHS 92.05 and 92.06 of the Wisconsin Administrative Code.*