



Release of Information Authorization - Ages 12 & up

Patients Name _____ DOB _____ Phone _____

Address _____ City, State, ZIP _____

Authorizes: The Caring Tree Children's Counseling Center, 227400 Rib Mountain Dr, Ste D, Wausau WI 54401, 715-301-0667

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

Name: _____ **Phone:** _____ **Fax:** _____

I authorize *The Caring Tree* to release and/or obtain the following written and/or verbal information/records:

- | | |
|---|--|
| <input type="checkbox"/> Medical treatment information | <input type="checkbox"/> School records |
| <input type="checkbox"/> Voicemail/Appointment verification | <input type="checkbox"/> Billing information about my account which may include health information |
| <input type="checkbox"/> Mental Health Assessment and Treatment notes | <input type="checkbox"/> Other specific information as follows: _____ |
| <input type="checkbox"/> Neuropsychology notes | |
| <input type="checkbox"/> To obtain copies or authorize release of my medical records, which may include authorizing release of medical records to other facilities on my behalf | |
| <input type="checkbox"/> Educational testing and/or information | |

Reason for the release: (INITIAL)

- | | | |
|--|--|--|
| <input type="checkbox"/> Continuing healthcare needs | <input type="checkbox"/> Second opinion/referral | <input type="checkbox"/> Billing, collection or claims |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Personal | <input type="checkbox"/> Legal/court proceeding |
| <input type="checkbox"/> Transfer of care | <input type="checkbox"/> Financial assistance | <input type="checkbox"/> Follow up |
| <input type="checkbox"/> Care Coordination/Case Mgmt | <input type="checkbox"/> Pre-employment/medical eval | <input type="checkbox"/> Other, specify: _____ |

Special medical record release by minor: 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/8 IDS 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 of release** _____

Patients Name _____ DOB _____

EXPIRATION. This authorization will remain in effect until (INITIAL ONE):

___ You cancel this authorization in writing. ___ The following event occurs, specify event: _____
___ Other: _____

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

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

Relationship to patient _____ **Phone number** _____

Fax the completed authorization to The Caring Tree at 715-870-2267; or email it to info@caringtree.net

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.