home of teens in control
Connections
COUNSELING

100 River Place, Suite 4
Madison, WI 53716
(608) 221-1500
Fax: (608) 221-1515

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. Client Information

Name – Last, First, MI		
Street Address		
City	State	Zip Code
Birthdate	Phone No.	

2. Type of information to be disclosed. *(Please check all applicable.)*

- ☐ All Clinic Records and Information
- ☐ Psychological Testing Report
- ☐ Behavioral Medicine Evaluation
- ☐ Medication Information
- ☐ Discharge/Termination Summary
- ☐ Letter Verifying Treatment Participation

Child/Adolescent School Records:

- ☐ M-Team Report
- ☐ Achievement Testing
- ☐ Behavioral Checklists
- ☐ Misc. School Records
- ☐ Other (specify): _____

- ☐ Hospital Records Including Reports
- ☐ Genetic Testing

3. Records Disclosed From/To:			4. Records Disclosed To/From:		
Name – (e.g. Health Facility, Physician) **Connections Counseling, LLC**			Name – (e.g. Health Facility, Physician)		
Address **100 River Place, Suite 4**			Address		
City **Madison,**	State **WI**	Zip Code **53716**	City	State	Zip Code
Phone **(608) 221-1500**	Fax **(608) 221-1515**		Phone	Fax	

5. Purpose or need for disclosure. *(Please check all applicable categories.)*

- ☐ Further Medical Care
- ☐ Coordination of Mental Health Services
- ☐ Payment of Insurance Claim
- ☐ Disability Determination
- ☐ Treatment Planning
- ☐ Legal Investigation
- ☐ Psycho-social Evaluation
- ☐ Vocational Rehabilitation Evaluation
- ☐ Telephone Consultation
- ☐ Other (specify): _____

6. This authorization will remain in effect until the disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. *(To specify an additional time period, please check one of the boxes below. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)*

- ☐ Other specific expiration date: _____(mm/dd/yr)
- ☐ Other expiration event (specify): _____

****PLEASE SEE REVERSE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

_____

Signature of Patient:_____Date:_____

(If signed by a person other than the patient, state relationship and authority to do so, see reverse side for other information about signatures).

Relationship:_____Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased ☐ Health Care Agent_____ ☐ Personal Representative of Deceased ☐ Other _____

ADDITIONAL INFORMATION REGARDING DISCLOSRE OF PATIENT MEDICAL INFORMATION

Connections Counseling, LLC honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, the providers at Connections Counseling may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect an disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to Connections Counseling, LLC, Attention: Medical Records Department, 100 River Place, Suite 4, Madison, Wisconsin 53716.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Medical Records Department at Connections Counseling, LLC.

Copying Fees. If you are requesting disclosure/release of medical information to other clinics, hospitals or health care providers for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact the Medical Records Department at Connections Counseling, LLC.