Authorization for Release of Information

MRN: ______________________
FOR OFFICE USE ONLY

SECTION 1: Person Whose Records Will be Released
Name: ______________________ **Date of Birth:** ________________ **Phone:** ___________________
Address: ____ **City:** _________________________ **State:** ____________

SECTION 2: Release type: (Check one) ☐Release To ☐Obtain From ☐Exchange information
SECTION 3: Release Format: ☐Verbal ☐ Written

Section 4: Agency/Organization Making Disclosure
Wellpoint Care Network, Inc. - Clinical Services
8901 W. Capitol Drive
Milwaukee, WI 53222
(414) 465-5770

SECTION 5: Agency/Organization I Authorize to Release Information
Agency/Professional: ____________________________________
Address: ____
City, State and Zip: ____________________________________
Phone: ____________ **Email:** ______________________________

SECTION 6: Dates of records being requested (if applicable): ___________________________________
SECTION 7: Type of records being requested:
I understand that the information may include diagnosis, prognosis, and/or treatment for physical, mental disorder, developmental disabilities, alcohol/drug abuse, or HIV results (excludes psychotherapy notes as defined in 45 CFR 164.501)

☐ Letter/Treatment	☐Summary Psychosocial History	☐Discharge Summary
☐Therapy Progress Reports	☐Psychiatric/ Psychological Evaluations	☐Prescriptions/Medications
☐Academic Progress Reports	☐Alcohol/Drug Abuse	☐Physical Examination
☐All	☐ Other (specify) ______________________________	

SECTION 8: Purpose or need for information: This authorization will expire in one year from date of signature unless otherwise specified: ____

PATIENT RIGHTS PERTAINING TO THIS AUTHORIZATION
Right to revoke this authorization: I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initiated above.
Right to receive a copy of this authorization: I understand that I have a right to receive a copy of this authorization.
Right to know potential for re-disclosure: I understand that the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information might be re-disclosed without my authorization.
Right to receive a copy of records to be released: The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. This authorization form is intended to be in conformance with Section 51.30(4)(d), Wisconsin Statutes and Sections HFS 92.03(3)(d) and 92.06, Wisconsin Administrative codes.
AODA records: Whenever records or communications concern alcohol and drug abuse (AODA), the release of such records will be in accordance with and under protection of 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records, which state: AODA treatment records which have been discloses are protect4ed by Federal Laws. Federal Regulation (42CFR Part 2) prohibits you from making any further disclosure without specific written consent, conforming to 2.31 of these regulations, of the person to whom these records pertain. The general authorization for the release of medical or other information is not sufficient for this purpose.
Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that treatment, payment, enrollment in health plan, or eligibility for health care benefits may not be contingent on my signing this authorization.

I authorize the release of copies of any medical treatment records accumulated after my signature through the expiration date of this consent form.

Signature of Client: ____ Date: ________________
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: ___________________________________ Date: ________________
(Required for Clients under age 18)

Witness Signature: ____Date: ________________