



PLATTEVILLE FAMILY RESOURCE CENTER, INC.

Authorization for Exchange of Information

All matters relating to client records are considered private and confidential and are treated as such by the staff of Platteville Family Resource Center. Information regarding such matters cannot be given without the consent of the client, unless evidence of child abuse exists, or a life-endangering situation exists, or the therapists are subpoenaed to testify in court.

- Instructions to Clients:**
- 1) Authorization for exchange of information is voluntary.
 - 2) The information to be released may be re-disclosed by the recipient to organizations not subjected to HIPAA and therefore may no longer be protected under HIPAA.
 - 3) Authorization for exchange of information for children under age 18 requires the signature of a parent or legal guardian.
 - 4) Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining authorization.

Client Name _____ DOB _____

If client is under age 18: Parent/Guardian _____ Relationship _____

I authorize _____ **of Platteville Family Resource Center, Inc. to:**

(PFRC staff name)

___ obtain from ___ release to (check one or both)

Agency/Individual Name _____

Address _____

Specific information to be **obtained** from the specified agency/individual by Platteville Family Resource Center, Inc.

Specific information to be **released** to the specified agency or individual by Platteville Family Resource Center, Inc.

Type: ___ Mental Health ___ Substance Abuse

Type: ___ Mental Health ___ Substance Abuse

Format: ___ Verbal report ___ Written records

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- ___ Legal status and court orders
- ___ Psychological assessment
- ___ Academic performance
- ___ Current treatment plan
- ___ Alcohol or drug (AODA) treatment history
- ___ Psychological Evaluation
- ___ Prior treatment summary (Time period: _____)
- ___ Physician Referral Form
- ___ Other (specify): _____

- ___ Client identification
- ___ Verification of session attendance
- ___ Psychosocial assessment
- ___ Current treatment plan
- ___ Closing Summary and Recommendations
- ___ Legal status and court orders
- ___ Prior treatment summary (Time Period: _____)
- ___ Other (specify): Diagnosis; presenting problem

Purpose or need for disclosure: (Check all that apply)

- ___ Coordination of care
- ___ Disability determination
- ___ Legal
- ___ Physician referral form
- ___ Evaluation and Treatment Planning

Back page must also be completed

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I understand that if the person(s) and/or organization(s) listed above as the recipients of my protected health information are not health care providers or health plans (health insurance companies) that the information I am authorizing the release of may no longer be protected by the federal or state privacy standards and my health information may be re-disclosed without obtaining my authorization I will hold harmless Platteville Family Resource Center and all of its branch offices from and against any and all liability in connection with the disclosure of protected health information as authorized herein. I understand I may inspect and arrange for photocopies of the information that will be disclosed as a result of this authorization.*** This authorization will remain in effect to carry out the purpose for which it is intended, but will not remain in effect for dates of service beyond the stated expiration date. I understand that I may revoke this authorization at any time (except to the extent action has already been taken in good faith reliance on this authorization) by submitting a written request to Platteville Family Resource Center. If I refuse to sign this authorization, my records/information will not be released.**

Signature of Patient

Date

Signature of Authorized Person

Date

Staff Witness Signature if applicable (Date)

Expiration Date of Authorization

(Will default to one year from date signed if no expiration date is given)

Relationship of Authorized Person Signature:

Parent Legal Guardian Court Appointed Temporary Guardian
 Power of Attorney for Healthcare* Authorized Legal Representative*

Patient is: Minor Incompetent Disabled Deceased Incapacitated

*Must have written proof that representative is Power of Attorney for Healthcare or Authorized Legal Representative and the document must state that the Authorized Person may obtain and/or sign for legal papers and/or medical information. The patient must be legally incapacitated in order for the Power of Attorney for Healthcare to sign in place of the patient.

** Exception: Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) indicate that those records are protected and cannot be disclosed or re-disclosed without the individual patient's written consent unless otherwise provided for in the regulations.

***If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies (\$.25/ page) you request for other purposes.

RIGHTS:

- # **Right to Inspect or Copy the Information to be Used or Disclosed.** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.
- # **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I can be provided with a signed copy.
- # **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.
- # **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Platteville Family Resource Center Medical Records Department. I am aware that my withdrawal will not be effective for uses or disclosures made previous to my withdrawal.

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL