

# Mental Health Solutions

7633 Ganser Way, Suite 204 • Madison, WI 53719  
P 608.829.1800 • F 608.829.1885

## AUTHORIZATION FOR RELEASE OF INFORMATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of Birth

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below, whom I am authorizing to use and/or disclose my health information, may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits based on my decision to sign this authorization.

I authorize \_\_\_\_\_ of Mental Health Solutions to release to/obtain information from the individual and/or agency listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Purpose/Reason for Disclosure:

- |   |  |
|---|--|
| <input type="checkbox"/> Evaluation/Assessment      | <input type="checkbox"/> Treatment Coordination  |
| <input type="checkbox"/> Further Psychological Care | <input type="checkbox"/> Process Insurance Claim |
| <input type="checkbox"/> Diagnosis                  | <input type="checkbox"/> Request of Client       |
| <input type="checkbox"/> Other _____                |  |

### Dates for which Information is Requested and/or Disclosed

(from \_\_\_\_\_ to \_\_\_\_\_):

- |  |  |
|--|--|
| <input type="checkbox"/> Intake Evaluation/Assessment        | <input type="checkbox"/> Medical Records           |
| <input type="checkbox"/> Alcohol/Drug Evaluation/Treatment   | <input type="checkbox"/> Inpatient Hospitalization |
| <input type="checkbox"/> Psychological Testing/Evaluation    | <input type="checkbox"/> Psychotherapy Notes       |
| <input type="checkbox"/> Psychiatric Evaluation/Consultation | <input type="checkbox"/> School Records            |
| <input type="checkbox"/> Other _____                         |  |

### Method of Contact:

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Ongoing    | <input type="checkbox"/> One-time Contact |
| <input type="checkbox"/> Telephone  | <input type="checkbox"/> In Person        |
| <input type="checkbox"/> In Writing | <input type="checkbox"/> Email            |

(OVER)

\_\_\_\_\_  
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**My Right To Revoke This Authorization:** I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact the treating therapist or staff person at Mental Health Solutions.

**Redisclosure of My Health Information:** Mental Health Solutions may not "redisclose" health information that has been received without specific written authorization. Under federal law, this restriction does not apply to non-health care entities.

**Fee For Records:** Mental Health Solutions may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill a request for "release of information". All fees are based on the applicable laws governing release of health information.

**Expiration of Authorization** This authorization will be *effective for one year* or until the following date or event: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

If client is a child or has a disability and is unable to sign, complete the following:

Name of Personal Representative and Relationship to Client: Parent, Guardian or Authority of Personal Representative (i.e., health care power of attorney, guardian, other statutory authorization):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_