THE PSYCHOLOGY CENTER
7617 Mineral Point Rd Ste 300 Madison, WI 53717
Phone: (608) 833-9290 FAX (608) 833-9691

AUTHORIZATION FOR DISCLOSURE or EXCHANGE of Confidential Medical Records

Regarding Patient **PLEASE COMPLETE IN FULL**

Name - Last, First, MI			
Street Address			
City		State	Zip Code
Birthdate	Phone No. (Home)	Phone No. (Work)	Phone No. (Cell/Other)

The Psychology Center, 7617 Mineral Point Rd Ste 300 Madison, WI 53717

X **Ray Koziol, PhD**
Physician/Therapist Name

By checking both of the boxes below, you are exchanging information.

☒ **Release To:** ☒ **Receive From:**

Organization Name (i.e., Insurance Co., Lawyer, Physician, Self...)		
Physician/Therapist/Attorney/Individual Name		
Street Address		
City	State	Zip Code
Phone	Fax	

Type or extent of information to be disclosed or exchanged.

A) ☐ **Specific records as follows:**
☐ Intake Assessment ☐ Psychiatric Reports ☐ Treatment Records
☐ AODA Assessment/Treatment Records ☐ Educational Records
☐ Evaluation Reports ☐ Psychological Testing ☐ Specific records pertaining to: _____
list date(s) or condition

B) ☒ Complete Copy of All Records including Mental Health Records, and excluding Psychotherapy Progress Notes.

C) ☒ **VERBAL** communication regarding my ongoing treatment and/or treatment plan.

Purpose or need for disclosure or exchange. ***(Check all applicable categories.)***

☐ further medical care
☐ psychotherapeutic treatment
☐ disability determination
☐ psychological evaluation
☐ vocational rehabilitation
☐ legal interface
☐ coordination with school
☐ coordination of treatment
☐ payment of insurance claim
☒ other **preemployment evaluation**

This authorization will remain in effect for one year and will include future records generated throughout that year unless you specify below that this authorization is effective for a specific time period. ***(More information on reverse side.)***

☐ Specific time period: _____
☐ **DO NOT** include future records.

In accordance with the specifications listed above, I authorize the disclosure or exchange of my records pertaining to mental health, alcohol and drug treatment, AIDS or AIDS related illness, and/or HIV test results. I may also receive a copy of this consent form. The client or person authorized has a right to inspect and, upon payment of usual fee, receive a copy of the material to be disclosed. I understand that I am under no obligation to sign this form and that treatment will not be denied if I refuse to sign this authorization. WI statutes 51.30 and 252.15 require patient authorization to disclose health information for payment purposes. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining my authorization.

As evidenced by my signature below, I hereby authorize disclosure or exchange of records to the person(s) or agency(s) as specified above.

Signature of Patient: X _____ **Date:** X _____

If signed by person other than patient, check relationship below and authority to do so. (More information on reverse side.)

FOR YOUR PROTECTION: We CANNOT accept a release without a WITNESSED & DATED signature of someone watching you sign.

Parent/Guardian Signature: _____

Patient is: ☐ Minor ☐ Incompetent ☐ Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Health care agent
☐ Personal representative of deceased
☐ Other _____

X _____
Witness Signature

X _____
Date Witnessed

Additional Information Regarding
RELEASE OF PATIENT MEDICAL RECORDS

The Psychology Center recognizes the patient's right to confidentiality of medical records as set forth in HIPAA and the Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

1) 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. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director, or designee, during the patient's treatment under certain exceptional circumstances. Federal law (HIPAA) grants extra privacy protection to psychotherapy notes and their release may be restricted.

2) The patient must specify the date, event, or condition upon which this release will expire. If not indicated, this authorization will automatically expire one (1) year from the date of signature. This release may be revoked by a patient in writing except to the extent that action has already been taken pursuant to the authorization. To revoke this authorization, the patient must send written notice of revocation to The Psychology Center, and to any other person or organization that has been authorized to release information pursuant to the authorization. Written revocations for The Psychology Center should be sent to The Psychology Center, 7617 Mineral Point Road, Suite 300, Madison, WI 53717-1623.

3) Generally, all patients 18 years of age or older must sign for release of their own medical records. Read the following to determine exceptions for patients older or younger than 18 years.

- All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply: 1) The patient is incompetent, 2) the patient is incapacitated and cannot sign the form, or 3) the patient is deceased.

- Patients 14 years of age or older may sign for release of medical records involving mental health or alcohol and drug treatment, as may the parent or guardian. Whenever possible, it is recommended that both the minor patient (14 years of age or older) and the parent or guardian authorize release of the records. When a patient is incapacitated, a person appointed as guardian or temporary guardian may sign. If the patient has given written authorization to another person to release information, the designated person can sign provided that written proof (such as a notarized power of attorney document) is made available.

- Generally, family members of living adult patients do not otherwise have authority to sign for the release of records. When the patient is deceased, the surviving spouse or personal representative of the patient may sign authorizations releasing records. When there is no surviving spouse, immediate family may consent. For this purpose, immediate family is limited to adult children, parents, grandparents, adult siblings of the deceased patient, and their spouses.

- All persons other than the patient who sign for release of records must state their relationship to the patient and have available proof of legal authority to release the records. The above summary does not address all of the complex exceptions which permit others to authorize release.

4) The Mental Health Records disclosed to you by this authorization are protected from re-disclosure by Wis. Admin. Code DHS 92.03. This Wisconsin Administrative code prohibits you from making any further disclosures of this information unless the disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical records or other information is not sufficient for this purpose.

A photocopy of this release shall be as effective as the original.