

NAME _____ DOB _____ SSN# _____
(also list maiden name/other names used)

I hereby request and authorize:

NORTH CENTRAL HEALTH CARE FACILITIES

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Wausau Campus 1100 Lakeview Drive Wausau, Wisconsin 54403 Phone: 715.848.4600 Fax: 715.842.2017 | <input type="checkbox"/> Merrill/Tomahawk Center 607 N. Sales Street, Ste 309 Merrill, Wisconsin 54452 Phone: 715.536.9482 Fax: 715.539.2972 | <input type="checkbox"/> Mount View Care Center 2400 Marshall Street Wausau, Wisconsin 54403 Phone: 715.848.4300 Fax: 715.843.5733 | <input type="checkbox"/> Antigo Center 1225 Langlade Road Antigo, Wisconsin 54409 Phone: 715.627.6694 Fax: 715.627.6645 |
|---|---|---|--|

To: Disclose to Receive from Exchange with

Name: _____

Address: _____

City/State/Zip: _____

The following specific information from my records for dates of treatment: _____

- For types of treatment:**
- | | | |
|--|---|---|
| <input type="checkbox"/> Mental Health/Psychotherapy | <input type="checkbox"/> Alcohol/Drug Therapy | <input type="checkbox"/> DD Services |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Nursing Home Record | <input type="checkbox"/> Aquatic Rehabilitation Therapy |
| <input type="checkbox"/> Birth-to-Three | <input type="checkbox"/> Outpatient Rehab Therapy | <input type="checkbox"/> Other, specify: _____ |

The purpose of such disclosure is: (check all that apply)

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Continuing Health Care Needs | <input type="checkbox"/> Personal | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Financial Assistance |
| <input type="checkbox"/> Care Coordination/Case Management | <input type="checkbox"/> Legal | <input type="checkbox"/> Disability | <input type="checkbox"/> Billing/Payment of Claims |
| <input type="checkbox"/> Other, specify _____ | | | |

Information to be Disclosed: (check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Verbal Information | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Discharge Summary/Note | <input type="checkbox"/> MD Notes |
| <input type="checkbox"/> Assessment Summary | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Letters/Correspondence |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Radiology/Lab Reports | <input type="checkbox"/> Questionnaires |
| <input type="checkbox"/> Progress Notes | | | |
| <input type="checkbox"/> Other ("all records" not acceptable), specify: _____ | | | |

I understand that I have a right to inspect and receive a copy of the materials to be disclosed as required under ss.DHS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I understand that this release allows for the exchange of HIV/Aids Testing, treatment and evaluations. I may revoke this authorization in writing at any time except to the extent that information already release pursuant to this consent cannot be recalled. [45 CFR 164.508(c)(2)(i)]. Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (42 CFR Part 2.35). I understand that information used/disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. I further understand that I am entitled to a copy of this signed consent at any time.

This authorization is effective for up to one (1) year from the date of signing, or as specified: _____

Patient/Client/Resident Signature: _____ Date: _____

Parent/Guardian/Other Signature, specify: _____ Date: _____

Staff Signature: _____ Date: _____

Staff Department: _____ Staff ID#: _____

(Fax/Copy as effective as the original)

AUTHORIZATION OF DISCLOSURE / RELEASE OF INFORMATION