North Central Health Care

Person centered. Outcome focused.

RELEASE OF INFORMATION

Name:_____________________________ **DOB:**____________ **MRN:**_________________

Consent Date: ______________________ Expiration Date: _____________________

I hereby request and authorize:

North Central Health Care Facilities

□ Wausau Campus □ Merrill/Tomahawk Center □ Antigo Center

□ Mount View Care Center □ Pine Crest Nursing Home

To: □ Disclose to □ Receive from □ Exchange with

______________________ ____________________________ ______________________
(First Name) *(Last Name)* *(Relationship to Client)*

____ ________________ ________________
(Address) *(Telephone Number)* *(Fax Number)*

The following specific information from my records for dates of treatment.
For types of treatment (check all that apply):

□ Crisis intervention □ Mental health/psychotherapy □ Nursing home records
□ Outpatient rehab therapy □ Alcohol/drug therapy □ Medical record
□ Aquatic rehabilitation therapy □ Developmental Disability services
□ Other (please specify): ____

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

□ Continuing health care needs □ Personal □ Transfer of Care
□ Financial Assistance □ Legal □ Disability
□ Billing/payment of claims □ Care coordination/case management
□ Other ____

Information to be disclosed (check all that apply):

□ Verbal information □ Psychiatric evaluation □ Discharge summary/note
□ Assessment summary □ Psychological evaluation □ Physical exam
□ Letters/correspondence □ Treatment plan □ Aftercare plan
□ Radiology/lab reports □ Questionnaires □ MD notes
□ Medication list □ Other (“all records” not acceptable)_______________________
____

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Name:____________________________ DOB:____________ MRN:_________________

I understand that I have a right to inspect and receive a copy of the materials to be disclosed as required under §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 released pursuant to this consent cannot be recalled. [45CFR 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 up to one (1) year from the date of signing, or as specified: _____________
Copy/Fax as effective as original.

_______________________________________ ___________________
Signature – Patient/Client *Date/Time Signed*

_______________________________________ _________________________ ___________________
Signature – Parent/Guardian/Other *Relationship* *Date/Time Signed*

Please return this form via mail, fax, or E-fax to:

North Central Health Care
Health Information Management
1100 Lake View Drive
Wausau, WI 54403

Fax: 715-842-2017
E-Fax: 715-261-0328