Clinical Psychology Associates, LLC

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I, _____, Date of Birth _____, Authorize Disclosure:

From/To: **Between** **To/ From:** _____

Clinical Psychology Associates, LLC
197 W. Chestnut St., Burlington, WI 53105

_____

_____

The Disclosure of the following specific information is authorized. NOTE: A separate authorization is necessary for the disclosure of psychotherapy notes.

__ Psychosocial History __ Psychiatric Evaluation __ Psychological Evaluation __ Treatment Schedule/Plan
__ Treatment Notes __ Physicians Orders __ Verbal Communications __ Discharge Summary
__ Lab Data/ x-ray __ Alcohol/ Drug Abuse __ Assessments (be specific) _____
__ Information from other agencies (Be Specific) _____
__ Other (Be Specific) _____

The Purpose of this Disclosure is:

☐ Further Medical Care ☐ Insurance Eligibility/ Benefits ☐ Personal ☐ Changing Providers
☐ Legal Investigation ☐ Other _____

NOTICE: YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive a Copy of this Authorization:
I understand that I am not required to sign this authorization, but that once I sign it I am entitled to be provided with a copy of the form.

Right to refuse to sign this Authorization:
I understand that I may refuse to sign this authorization. I understand that Clinical Psychology Associates will not condition treatment, payment, and enrollment in a health plan or eligibility for health care benefits on my decision to sign or refuse to sign this authorization. Clinical Psychology Associates may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of a valid authorization for the disclosure of the protected health information to a third party.

Right to Revoke This Authorization:
I understand that I may revoke this authorization in writing except to the extent that action has been taken in reliance on it. I understand that I may revoke this Authorization by notifying the medical records/health information department in writing. If you need assistance you may contact the Privacy Officer at 262-763-9191.

Right to know the potential for Redisclosure:
I understand that once information is disclosed pursuant to this signed authorization, federal privacy laws (45 CFR Part 164) protecting health information may not apply to this recipient of the information, and therefore may not prohibit the recipient form redisclosing it without my authorization.

The following notice shall accompany all disclosed information regarding drug and alcohol abuse clients: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." The patient has the right of access to medical record information as provided under HFS 92.05 and 92.06.

This Authorization shall expire on the following date _____ or event _____
Or 1 (one) year from the date it is signed, whichever is earlier.

SIGNATURES

_____ **Date:** _____
Signature of Client (Minors included)

_____ **Date:** _____
Signature of legally responsible person or personal representative (if required)

Please explain representative's authority to act on behalf of client: _____