Lake Geneva Wellness Clinic

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I, _____, Date of Birth _____, authorize disclosure:
Name of client or individual

FROM/TO: BETWEEN TO/FROM: _____

☐ Lake Geneva Wellness Clinic
101 Broad Street Suite 201
Lake Geneva, WI 53147
Ph. (262)248-7942
Fax (262)248-1202

☐ Wheatland Location
6606 368th Ave
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 ___Physician's 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:
π Further Medical Care π Insurance Eligibility/Benefits π Personal π Changing Providers
π Legal Investigation or Action π 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 must 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 Lake Geneva Wellness Clinic will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign or refuse to sign this authorization. Lake Geneva Wellness Clinic 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 except to the extent that action has been taken in reliance on it. I understand that written notification is necessary to withdraw this authorization. The procedure to revoke this authorization is found in Lake Geneva Wellness Clinic Privacy Notice, or if you need assistance you may contact the Privacy Officer at 262- 248-7942

Right to Know the Potential for Redisclosure
I understand that once information is disclosed pursuant to this signed authorization, federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information, and therefore may not prohibit the recipient from 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:_____