Authorization for the Disclosure of Health Information

Patient's Legal Name: _____

Patient's Date of Birth or MRN: _____

I authorize Fox Valley Psychiatry Ltd. to (*please "✓" one or both*):

☐ **DISCLOSE** written and/or verbal protected health information **TO** the person or organization named below.

☐ **OBTAIN** written and/or verbal protected health information **FROM** the person or organization named below.

_____

Name of Person and/or Organization

_____

Address/City/State/Zip and/or Phone or Fax Number

Fox Valley Psychiatry does not release information via email for privacy concern reasons. Instead information will be printed and mailed to the recipient or faxed. There is a $25 fee for records requests if a large amount are needed. If you only need a letter summarizing your care, only click "Letter" below and state what you specifically need in the letter here: _____

I authorize the disclosure of the following specific written or verbal information (please "✓" each box that applies):

☐ Psychiatric progress notes/evaluation ☐ Billing Records ☐ Appointment dates

☐ Medication list ☐ Labs ☐ Letter

☐ Other *(please specify)*: _____

For the following dates: If neither box is checked, information from the last 2 years will be disclosed by default.

☐ All **--- OR ---** ☐ From: _____ To: _____

Disclosure of this information is for the purpose of *(please "✓" each box that applies)**:***

☐ Continuation or transfer of care ☐ Insurance ☐ Legal purposes ☐ Personal use ☐ Other (list):

This authorization expires on the following date or when the following event takes place:

_____

If no expiration date or event is noted here, this release will expire upon the minor patient's 18th birthday or, if the patient is 18 or older, this release will expire one year from the date of signature.

I acknowledge that I have reviewed the "Your Rights with Respect to this Authorization" section on Page Two of this form.

If patient is a minor please fill out all fields with guardian information

_____
Print Name of Patient

_____ _____
Signature of Patient (if age 14 or older) Date

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient

_____ _____
Signature of Parent/Legal Guardian Date

Authorization for the Disclosure of Health Information

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have the right to receive a copy of this authorization.

Right to refuse to sign this authorization: You understand that this authorization is voluntary and that you may refuse to sign it. Fox Valley Psychiatry Ltd. will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. Please note Fox Valley Psychiatry does not participate in any research endeavors and thus will not submit any protected health information to other entities for research or other non-direct patient care purposes.

Right to terminate this authorization: You have a right to revoke this authorization at any time. You must submit written notification of your desire to revoke this authorization to Fox Valley Psychiatry Ltd., Attn: Medical Records, 4321 W College Ave, Ste 200, Appleton, WI 54914 . You should be aware that your withdrawal will not be effective until received by Fox Valley Psychiatry Ltd. and will not be effective regarding the use of disclosures made prior to Fox Valley Psychiatry's receipt of your revocation.

Right to inspect and or receive a copy of the information: You have a right to review and/or request a copy of the information you authorized to be used or disclosed by this authorization as required under Wis. Admin. Code DHS ss. 92.05 and 92.06. There may be a charge for these copies as permitted by Wis. Stat. § 146.83 (3f) (c) 2. You may arrange to inspect your file or obtain copies of this information by contacting Fox Valley Psychiatry Ltd.

Prohibition on re-disclosure: Information disclosed via this authorization may potentially be re-disclosed by the recipient and may no longer be protected by federal and state privacy and confidentiality rules.

This authorization form can be faxed to us (preferred) or sent by postal mail.

Fax

920-214-1187

Mail

Attn: Medical Records
Fox Valley Psychiatry Ltd.
4321 W College Ave, Ste 200, Appleton, WI 54914

Phone

(920) 882-7780 (call if you have questions)