MIDWEST PSYCHOLOGICAL SERVICES

Authorization to Release Protected Health Information

Client Number	Name (*First, Middle, Last*)	Birth Date (*Month, DD, YYYY*)

Instructions: If **any** section is incomplete, this form may be invalid.

Release, Obtain, or Exchange Information To/From

☐ Midwest Psychological Services, 2501 Hanley Rd, Suite 202, Hudson, WI 54016-8705
Provider: _____

☐ Other *(Specify facility/Individual & address below, including phone/fax if known)*

_____
_____
_____
_____

Release, Obtain, or Exchange Information To/From

☐ Midwest Psychological Services, 2501 Hanley Rd, Suite 202, Hudson, WI 54016-8705
Provider: _____

☐ Other *(Specify facility/Individual & address below, including phone/fax if known)*

_____
_____
_____
_____

Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes
☐ Application for Insurance ☐ Disability Determination ☐ Payment on Insurance Claim
☐ Other _____

Information to be Released

☐ Admissions/Intake ☐ Diagnostic Impressions ☐ Progress Notes
☐ Psychiatric Evaluations ☐ Academic Records/ School Functioning ☐ Discharge/Treatment Summary
☐ Social/Court Services Summary ☐ Psychological Testing/Evaluation ☐ Phone Consultation
☐ Laboratory tests ☐ Other _____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for the copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to the redisclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form.
  - Please indicate your legal authority and include documentation of your relationship:
    ☐ Legal guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

Signature (Required)		**Date Signed** (Required) (Month, DD, YYYY)	
Printed Name of Person Signing (If Not Patient)			
Mailing Address of Client – Street			
City	State	ZIP Code	Phone