

Authorization to Release Protected Health Information

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

NOTE: If any section is incomplete, this form may be invalid

Who has the information you want released?

<input type="checkbox"/> Midwest Psychological Services <input type="checkbox"/> Other: _____ Address: _____ Phone: _____ Fax: _____
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Where do you want the information released?

<input type="checkbox"/> Midwest Psychological Services Ph. 715-381-1980 Fax 855-246-2595 <input type="checkbox"/> Other: _____ Address: _____ Phone: _____ Fax: _____
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Purpose of Release

- | | | |
|--|---|--|
| <input type="checkbox"/> Treatment/ Continued Care | <input type="checkbox"/> Personal | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Application for Insurance | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Insurance Claim |
| <input type="checkbox"/> Other _____ | | |

Information to be Released

- | | | |
|--|---|---|
| <input type="checkbox"/> Admissions/Intake | <input type="checkbox"/> Diagnostic Impressions | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Academic/ School Records | <input type="checkbox"/> Discharge/ Treatment Summary |
| <input type="checkbox"/> Social/Court Services | <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Phone Consultation |
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> 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.

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

<p>ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.</p> <ul style="list-style-type: none"> ● 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: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Legal Guardian or Conservator</td> <td><input type="checkbox"/> Health Care Agent (Health Care Power of Attorney)</td> </tr> </table> ● 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: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian 	<input type="checkbox"/> Legal Guardian or Conservator	<input type="checkbox"/> Health Care Agent (Health Care Power of Attorney)
<input type="checkbox"/> Legal Guardian or Conservator	<input type="checkbox"/> Health Care Agent (Health Care Power of Attorney)	

Signature (Required) _____

Date Signed _____

Printed Name _____

Phone _____

Mailing Address (Street, City, State, Zip) _____