AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

The disclosure of medical records can take up to 21 days to research and process. The minimum fee to disclose information is $25.00 and needs to be paid prior to processing. You may be billed an additional amount if the records exceed 25 pages. Please ask for fee schedule.

Patient Information:

_______________________________ _____________ __________ ____________________
Name of Patient/Previous Name(s) Birth Date Age Phone Number

_______________________________ ____________________ __________ ____________
Street Address City State Zip

Authorize American Behavioral Clinics to: Disclose to or Receive from Verbally or Written

(*one or both boxes can be checked)* Records will be sent and requested if both boxes are checked. Please note that a fee may be charged if records are to be disclosed.

Organization/Individual: ____

at ____
*Address City State Zip

______________________________ ______________________________
Phone Number Fax Number

**Release will be returned if address is left blank (unless fax number is provided)*

In compliance with Wisconsin Statues which requires special permission to disclose otherwise privileged information, I am authorizing that the following information be disclosed:

(Information To Be Disclosed: Identify below the specific information you are authorizing to be disclosed)

Mental Health Records (excluding "psychotherapy notes" as defined in HIPAA at CFR164.501) Which will include all items * below

Billing Records *Discharge Summary *Evaluations *Physician Notes *Drug/Alcohol or Substance Abuse Records

Other (please specify) ____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

Alcohol/Drug Abuse HIV Test Results Other (must specify) ______________________________

DATE(S) OF INFORMATION TO BE DISCLOSED: From__________________to__________________ If left blank, information from last 2 years will be disclosed.

PURPOSE OF DISCLOSURE: Continuity of Care Personal Care Legal **(**Other) ______________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Inspect or Receive a Copy of Health Information to be Used or Disclosed – I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and ABC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. ***Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ABC's Release of Information Department at 7330 W. Layton Ave, Milwaukee, WI 53220. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; (2) this authorization is obtained as a condition for obtaining insurance coverage. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results**: I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations are available upon request. ****WI Statues 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as original**.

This information has been disclosed to you from records protected by Federal (42CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

EXPIRATION DATE: This authorization is valid until the following dates(s)______________________________ or 6 months from the date signed.

SIGNATURE OF PATIENT: ______________________________________ DATE: ______________
PATIENT MUST SIGN IF AGE 14 OR OLDER

SIGNATURE OF PARENT: ______________________________________ DATE: ______________
By signing above, I hereby declare that I have not been denied physical placement of this child

____ DATE: ______________
SIGNATURE OF LEGAL REPRESENTATIVE Relationship

This release originated from the following location. Any correspondence should be directed here:

- ☐ 7330 W. Layton Ave, Milwaukee, WI 53220 Ph: 414-281-1677 / Fax: 414-281-9884
- ☐ 1240 Ranchito Ln, Mequon, WI 53092 Ph: 262-241-3231 / Fax: 262-241-4311
- ☐ 10424 W Bluemound Rd, Milwaukee, WI 53226 Ph: 414-774-1794 / 414-774-1488
- ☐ 15285 Watertown Plank Rd, Elm Grove, WI 53122 Ph: 262-797-2818 / 262-797-2814