Alay
HEALTH TEAM
MENTAL HEALTH & WELLNESS SERVICES
EST 2016

ALAY HEALTH TEAM AUTHORIZATION
FOR USE & DISCLOSURE OF HEALTH/ CONFIDENTIAL RECORDS
ALL SECTIONS MUST BE COMPLETED (1 through 10*)

Section 1: PATIENT INFORMATION (PLEASE PRINT OR WRITE IN BOX) **TODAYS DATE**: _____
NAME _____ **DATE OF BIRTH**: _____
ADDRESS: _____ **CITY**: _____ **STATE**: ___ **ZIP CODE**: _____
PHONE NUMBER: _____ **EMAIL**: _____

Section 2: PATIENT GIVES PERMISSION TO:
☐ **DISCLOSE** ☐ **OBTAIN FROM** ☐ **EXCHANGE INFORMATION WITH**
NAME OF INDIVIDUAL/AGENCY/ORGANIZATIONS/OTHER: _____
ADDRESS: _____ **CITY**: _____ **STATE**: ___ **ZIP CODE**: _____
PHONE NUMBER: _____ **FAX**: _____
*MUST HAVE FAX OR ELSE NO RECORDS WILL BE FAXED

Section 3: I AUTHORIZE THIS INFORMATION TO BE SHARED/DISCLOSED FROM/TO:
NAME OF INDIVIDUAL/AGENCY/ORGANIZATIONS/OTHER: ALAY HEALTH TEAM (CORPORATE)
PROVIDER NAME IF APPLICABLE: _____
ADDRESS: 2351 SILVERNAIL ROAD **CITY**: PEWAUKEE **STATE**: WI **ZIP CODE**: 53072
PHONE NUMBER: 262-260-9000 **FAX**: 262-260-9109

Section 4: Information to be released/ disclosed: (mark x= yes, blank= no)
Note: Information to be released may be in written, verbal, voicemail, fax or electronic form
☐ All Records OR
- ☐ Intake/Initial Assessment
- ☐ Medications
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Discharge Summary
- ☐ Insurance/Billing
- ☐ Oral/UDS Testing
- ☐ Diagnosis Codes
- ☐ Appointments/Attendance
- ☐ Laboratory Reports

Section 5: Date records are needed by: _____
****Please note it can take up to 30 days for records to be sent out* - We do not do immediate records request.**

Section 6: Dates of Information to be disclosed: FROM: _____ TO: _____

Section 7: In compliance with state statutes, which require special permission to release otherwise privileged information, please release records pertaining to: (check all that apply)
- ☐ Alcohol or Drug Abuse/Treatment (AODA)
- ☐ Developmental Disabilities
- ☐ HIV/AIDS
- ☐ Mental/Behavioral Health Conditions
- ☐ Sexually Transmitted Diseases

Section 8: Purpose of disclosure: (check all that apply)
- ☐ Collaboration of Care
- ☐ Transfer of Care
- ☐ Legal Matters
- ☐ Personal
- ☐ Disability
- ☐ Insurance/Eligibility/ Benefits
- ☐ Other_____

This authorization lasts for **one year** after the date you sign it unless you enter a different date or expiration date here: _____

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Additional Information Regarding RELEASE OF PATIENT MEDICAL RECORDS

Alay Health Team recognizes the patient's right to confidentiality of medical records as set forth in HIPAA and the Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

1) The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and upon paying any applicable fees, may obtain a copy to be disclosed pursuant to this consent form. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director, or designee, during the patient's treatment under certain exceptional circumstances. Federal law (HIPAA) grants extra privacy protection to psychotherapy notes and their release may be restricted, Section 51.30, Wis, Stats., DHS 92.03-92.06 Wis. Adm. Code.

2) The patient must specify the date, event, or condition upon which this release will expire. If not indicated, this authorization will automatically expire one (1) year from the date of signature. This release may be revoked by a patient in writing except to the extent that action has already been taken pursuant to the authorization. To revoke this authorization, the patient must send written notice of revocation to Alay Health Team, and to any other person or organization that has been authorized to release information pursuant to the authorization. Written revocations for Alay Health Team should be sent to Alay Health Team, 2351 Silvernail Road Pewaukee, WI 53072

3) Generally, all patients 18 years of age or older must sign for release of their own medical records. Read the following to determine exceptions for patients older or younger than 18 years.

- All patients 18 years of age and over must sign for release of their own medication records unless the following conditions apply: 1) The patient is incompetent, 2) the patient is incapacitated and cannot sign the form, or 3) the patient is deceased.
- Patients 14 years of age or older may sign for release of medical records involving mental health or alcohol and drug treatment, as may the parent or guardian. Whenever possible, it is recommended that both the minor patient (14 years of age or older) and the parent or guardian authorize release of the records. When a patient is incapacitated, a person appointed as guardian/custodian or temporary guardian may sign. If the patient has given written authorization to another person to release information, the designated person can sign provided that written proof (such as a notarized power of attorney document) is made available.
- Generally, family members of living adult patients do not otherwise have authority to sign for the release of records. When the patient is deceased, the surviving spouse or personal representative of the patient may sign authorizations releasing records. When there is no surviving spouse, immediate family may consent. For this purpose, immediate family is limited to adult children, parents, grandparents, adult siblings of the deceased patient, and their spouses.
- All persons other than the patient and have available proof of legal authority to release the records. The above summary does not address all of the complex exceptions which permit others to authorize release.

The Mental Health Records disclosed to you by this authorization are protected from re-disclosure by Wis. Admin. Code DHS 92.03(s)(d) This Wisconsin Administrative code prohibits you from making any further disclosures of this information unless the disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical records or other information is not sufficient for this purpose. If patient refuses to sign the authorization form required by HIPAA see 45 CFR Part 164.508 (c)(2)(ii)

This request may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Alay Health Team Notice of Private Practice describes how to cancel (revoke) this authorization

A photocopy/fax/image of this authorization will be treated in the same way as the original

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Alay Health Team records may include records which it received from other organizations. If these records have been used by Alay Health Team and filed in the Alay Health Team records about you, these records may be released with your Alay Health Team records. Alay Health Team cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

By signing this authorization, you release Alay Health Team from any and all liability resulting from disclosure by the recipient.

Your signature indicates that you have **read** and **understand t**his form and authorize release of your information as described above.

Section 9: DO NOT SIGN BOTH BOXES, PLEASE READ BELOW-
IF YOU ARE THE PATIENT COMPLETE HERE

_____ _____
Printed Name of Patient **Signature of Patient**

***IF YOU ARE NOT THE PATIENT COMPLETE HERE AND FILL OUT SECTION 10**:

_____ _____
Printed Name of Legal Guardian **Signature of Legal Guardian (if patient under 18)**
(If patient is under 18 or has legal guardian)

Section 10*: If signed by a person other than the patient, then check any and all that apply and mark who the guardian is:

Patient is:
- ☐ Minor
- ☐ Incompetent
- ☐ Unable to sign due to disability
- ☐ Deceased

Legal Authority:
- ☐ Parent of minor
- ☐ Power of Attorney*
- ☐ Legal Guardian*
- ☐ Other: _____

*if you circle any of the above, you must have proof of legal authority attached to this authorization or on file in patient's chart before any records will be released. (i.e. Guardianship papers, Power of Attorney documents, etc.)