PSYCHIATRIC CONSULTANTS AND THERAPISTS, S.C.
229 E. Wisconsin Ave. Suite 600
Milwaukee, WI 53202
Phone: 414-224-3737
Fax: 414-224-1522

AUTHORIZATION FOR DISCLOSURE OF HEALTH OR FINANCIAL INFORMATION

1. Patient Name: _____ DOB:_____
   ADDRESS:_____
   CITY/STATE/ZIP:_____ PHONE NUMBER:_____

2. Person/Organization Authorized to RELEASE patient's health information:
   Health Care Agency: _____
   Address:_____
   _____

3. Person/Organization Authorized to RECEIVE patient's health information
   Health Care Agency:_____
   Address:_____
   _____

4. Delivery Options:
   a. ___Mail
   b. ___Verbal Exchange
   c. ___Other_____

5. Information To Be Disclosed:
   a. ___Progress Notes
   b. ___Group Notes
   c. ___Medications
   d. ___Billing Records
   e. ___Intake Assessment
   f. ___Dates of Attendance
   g. ___Psychological Testing/Results
   h. ___Lab Results

6. I DO NOT want the following information to be disclosed:
   a. ___Human Immunodeficiency Virus (HIV) Test Results
   b. ___Alcohol and Drug Abuse Records
   c. ___Developmental Disability Records

7. Purpose/Need for Disclosure
   a. ___Coordination/Continuation of Care
   b. ___Legal Investigation
   c. ___Patient Request
   d. ___Other:_____

8. Patient Rights: I have the right to revoke this authorization, in writing, at any time by sending written notification to Psychiatric Consultants and Therapists, S.C. at 229 E. Wisconsin Ave. Suite 600, Milwaukee, WI 53202. I understand that a revocation of the authorization is not effective to the extent that an action has been taken in reliance on the authorization.

9. Expiration Date: This authorization is good until the following date(s):_____

If not date is specified, this authorization will expire one (1) year from the date signed.

**PROHIBITION ON REDISCLOSURE: This information is protected by Federal and Wisconsin Confidentiality Laws. Such laws prohibit 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 such laws. A general authorization for the 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. I have had an opportunity to review and understand the content of the authorization. By signing this authorization, I am confirming that it accurately reflects my wishes.

10. Signature of Patient/LegalRep:_____Date:_____

    Relationship or authority to or for the patient:_____

    (If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement would endanger the child's physical, mental, or emotional health.)

11. Witness (When applicable):_____Relationship:_____

    Date:_____