North Central Health Care
Person centered. Outcome focused.

RELEASE OF INFORMATION

Name:_____ **DOB:**_____ **MRN:**_____

Consent Date: _____ Expiration Date: _____

I hereby request and authorize **North Central Health Care Facilities:**

- ◯ Wausau Campus
- ◯ Merrill Center
- ◯ Antigo Center
- ◯ Mount View Care Center
- ◯ Pine Crest Nursing Home

To: ◯ Disclose to ◯ Receive from ◯ Exchange with

_____ _____ _____
(First Name) *(Last Name)* *(Relationship to Client)*

_____ _____ _____
(Address) *(Telephone Number)* *(Fax Number)*

OR

_____
(Non-Treatment Provider, Description of Group, or Class of Treatment Provider)

The following specific information from my records for dates of treatment.
For types of treatment (check all that apply):

- ◯ Mental health services
- ◯ Substance Use Disorder Services (Part 2 Program)
- ◯ Developmental Disability services
- ◯ Other (please specify): _____
- ◯ Nursing home records
- ◯ Aquatic rehabilitation therapy
- ◯ HIV test results

The purpose of such disclosure is _____

[*describe the purpose of the disclosure, should be as specific as possible. i.e., for HIPAA only: continuing health care needs, legal, care coordination, etc., for Part 2 patients, billing/payment, treatment, and operations.*]

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Health Information to be disclosed (check all that apply):

◯ Verbal information	◯ Psychiatric evaluation	◯ Discharge summary/note
◯ Assessment summary	◯ Psychological evaluation	◯ Physical exam
◯ Letters/correspondence	◯ Treatment plan	◯ Aftercare plan
◯ Lab reports	◯ Questionnaires	◯ MD notes
◯ Medication list	◯ Progress Notes	

◯ Other ("all records" not acceptable)_____

HIPAA Disclosure Statements

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that North Central Health Care 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 the below addressee. I am aware that my withdrawal will not be effective until received by Health Information Department and will not be effective regarding the uses and/or disclosures of my health information that North Central Health Care has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Department.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

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Substance Use Disorder Treatment (Part 2) Disclosure Statements

Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (42 CFR Part 2.35). I understand that information used/disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. I further understand that I am entitled to a copy of this signed consent at any time.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____

(Date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent)

I understand that I may be denied services if I refuse to consent to disclose for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Copy/Fax as effective as original.

_____ _____

Signature – Patient/Client *Date/Time Signed*

_____ _____ _____

Signature – Parent/Guardian/Other *Relationship* *Date/Time Signed*

Please return this form via mail, fax, or E-fax to:

North Central Health Care
Health Information Management
2400 Marshall Street Suite A
Wausau, WI 54403
Phone: 715-845-4326
Fax: 715-842-2017
E-Fax: 715-261-0328