Beloit Health System
1969 W. Hart Rd.
Beloit, WI 53511-2230

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

PATIENT INFORMATION

LAST NAME FIRST MIDDLE DATE OF BIRTH (/ /)

STREET ADDRESS CITY,STATE,ZIP PHONE NUMBER

I HEREBY AUTHORIZE AND REQUEST:

Counseling Care Center

1969 W. Hart Road

Beloit, WI 53511

Phone: 608−364−5686

Fax: 608−363−5756

_____TO RELEASE TO

_____TO RECEIVE FROM

_____TO RELEASE TO AND RECEIVE FROM

ORGANIZATION/INDIVIDUAL

STREET ADDRESS

CITY,STATE,ZIP

PHONE FAX

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:_____Mental Health _____HIV Status _____Alcohol and/or Drug Abuse

Specific Information Requested:

_____Psychosocial History
_____Physical Examination
_____Treatment Plan
_____Physician's Orders
_____Psychological Evaluation
_____Psychiatric Evaluation
_____Psychiatric Treatment Notes
_____Psychotherapy Treatment Notes
_____AODA Assessment
_____AODA Treatment Notes
_____Appt./Confirmation/Referral
_____Discharge Summary
_____School Records
_____Lab Data
_____Other _____

Service dates to be released: From_____to_____

Purpose for need of disclosure: (please check all that apply)

_____Further Medical Care _____Coordinating Care for Dependent/Spouse _____Insurance
_____Claims Resolution _____Other _____

I understand that I have the right to copy and inspect the information that is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness.

It is further understood that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing. I understand that the withdraw will not apply to information that has already been released in response to this authorization, and that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following day or event: _____. If I fail to specify an expiration date, this authorization will expire in six months.

I understand that any disclosure of information carries with it the potential for an unauthorized re−disclosure and may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form in order to assure treatment. I may experience consequences for not signing this authorization if referred from a mandatory agency. (i.e. employer, courts).

I understand that I have the right to have a copy of this signed consent.

Signature of Patient (Includes minors 14 years of age and over) Date Signed

Signature of Parent/Guardian/Personal Representative (Relationship) Date Signed

Signature of Witness Date Signed

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT INFORMATION

Beloit Health Systems recognizes the patient's right to confidentiality of medical records as in the Illinois and Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

Both Illinois and Wisconsin Statutes recognize the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of your signature, UNLESS it is the authorization to release "future records of a specific test, specified clinic appointment and/or admission with the month and year identified."

All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

* The patient is incompetent.
* The patient is disabled and cannot sign the form.
* The patient is deceased. (The surviving spouse or legal representative must sign authorization releasing records of the deceased person.)

Patients less than 18 years of age must sign for release of the medical records when:

* The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, or drug dependency.
* The patient's records for release include abortion.

All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

For continuation of care, pertinent portions of your medical information will be sent to your physician/medical facility free of charge. All other requests are subject to fees. Some record requests may require pre−payment. If your request requires pre−payment an invoice will be sent to you with instructions on how to submit payments. If payment is required, the records will be sent after the payment is received.

If you have any questions regarding the above information, please do not hesitate to ask us.