BARBARA L. HALE-RICHLEN, M.D, F.A.P.A.

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH AND/OR ALCOHOL/DRUG ABUSE INFORMATION

(Consent)

1. _____
Name Address City State Zip

_____ (_____)_____
Date of Birth Daytime Phone Previous Name

2. **AUTHORIZES:**

Barbara L. Hale-Richlen, M.D. F.A.P.A.
Name of Health Care Provider/Plan/Other

12720 W. North Ave. Building B. Brookfield, WI 53005
Address

3. **TO DISCLOSE TO AND/OR RECEIVE FROM**:

_____
Name of Health Care Provider/Plan/Other Phone #

_____
Address Fax #

4. ☒ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL** (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below).

5. **DATE(S) OF INFORMATION TO BE DISCLOSED**: From _____ to _____ **If left blank, information from the past three (3) years will be disclosed**. (month/year) (month/year)

6. **INFORMATION TO BE DISCLOSED:** ☒ **Verbal** ☒ **Written**

- ☐ **Alcohol/Drug Abuse Assessment**
- ☐ **Identity and Presence in Treatment**
- ☐ **Medications/Medication Profile**
- ☐ **Psychiatric Evaluation**
- ☐ **History and Physical**
- ☐ **Billing Records**
- ☐ **Discharge Instructions**
- ☐ **Initial Mental Health Assessment**
- ☐ **Outpatient Mental Health Records**
- ☐ **Psychosocial Assessment**
- ☐ **Legal Status/Court Records**
- ☐ **ALL RECORDS**
- ☐ **Discharge Summary**
- ☐ **Lab Results**
- ☐ **AODA Records**
- ☐ **Treatment Plan**
- ☐ **Progress Notes/Updates**
- ☐ **Other (specify): _____**

☐ **CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXIST) TO BE DISCLOSED.**

☒ **I also specifically authorize release of my medical information created after the date of my signature.**

7. **EXPIRATION**: This authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in two (2) years from the date signed.

8. **PURPOSE (check applicable):**

- ☐ **Care Coordination**
- ☐ **Legal Investigation/Action**
- ☐ **Compliance with Treatment**
- ☐ **Further Follow Up Care**
- ☐ **Obtain Collateral Information**
- ☐ **Other: _____**
- ☐ **Insurance Eligibility/Benefits**
- ☐ **Personal (my request)**

9. **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim / policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and /or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10. **SIGNATURE OF PATIENT**: _____ **DATE**: _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE**: _____

If signed by a LEGAL REPRESENTATIVE, complete the following:

A**: Individual is:** ☐a minor ☐legally incompetent or incapacitated ☐deceased

B: **Legal Authority is**: ☐a parent* ☐legal guardian ☐next of kin/executor of deceased ☐activated POA for healthcare

***By signing above, I hereby declare that I have not been denied physical placement of this child**

12720 W North Ave.-Building B
Brookfield, WI 53005
262-785-1500
262-785-1555 Fax #