BIRCHWOOD
THERAPEUTIC SERVICES

AUTHORIZATION FOR DISCLOSURE/EXCHANGE OF HEALTH INFORMATION

PATIENT:

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

AUTHORIZES:

Name of Health Care Provider/Agency _____

Street Address _____

City, State, Zip Code _____

Phone / Fax _____

EXCHANGE OF PROTECTED HEALTH INFORMATION WITH:

Name of Health Care Provider/Agency: Birchwood Therapeutic Services

Street Address _____

City, State, Zip Code _____

Phone / Fax _____

☐ **Requesting information** ☐ **Releasing Information**

Information to be shared:

_____ Diagnostic Assessment
_____ Labs
_____ Discharge Summary
_____ Consultations
_____ Progress Notes
_____ Other (specify)_____

In compliance with Wisconsin and Minnesota Statutes which require special permission to release otherwise privileged information please release records pertaining to:

_____ Alcohol Abuse or test results
_____ Developmental Disabilities
_____ Drug Abuse or test results
_____ Mental Health
_____ Other (specify)_____

This disclosure is being made for the following purpose(s):

_____Continuing medical care
_____Relocation/moving
_____Insurance/EAP
_____Legal
_____Other_____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and /or no longer protected by the Federal Privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy 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 Services Dept.

Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization I will be provided with a copy of it if requested.

Right to Refuse to Sign This Authorization – I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party in which care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services).

Right to Revoke This Authorization – I understand written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date_____or for one year from date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP:_____DATE:_____

(If signed by other than the patient, indicate relationship and authority to do so.)

( )Parent ( )Guardian ( )POA for Healthcare ( )Spouse ( )Adult Family Member of deceased patient