Operated by Beloit Memorial Hospital
1969 West Hart Road, Beloit, WI 53511
608.364.5686 (Phone) 608.363.5756 (Fax)
beloitmemorialhospital.org

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 _____ TO RELEASE TO _____ ORGANIZATION/INDIVIDUAL

1969 W. Hart Road _____ TO RECEIVE FROM _____ STREET ADDRESS

Beloit, WI 53511 _____ TO RELEASE TO AND RECEIVE FROM _____ 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 _____ Psychiatric Evaluation _____ Appt./Confirmation/Referral
_____ Physical Examination _____ Psychiatric Treatment Notes _____ Discharge Summary
_____ Treatment Plan _____ Psychotherapy Treatment Notes _____ School Records
_____ Physician's Orders _____ AODA Assessment _____ Lab Data
_____ Psychological Evaluation _____ AODA Treatment Notes _____ 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 withdrawal 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 Unless otherwise withdrawn, this authorization will expire on the following day or event: _____.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 this authorization. I need not 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

_____ _____

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Signature of Witness

Date Signed