Appleton Psychiatric & Counseling Center

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Appleton, WI 54914

Office (920) 882-6610 Billing (920) 882-6612 Fax (920) 882-6611

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION (PHI)

Client Name:_____ DOB:_____
Previous Names associated with Patient

I AUTHORIZE:	**TO EXCHANGE PHI WITH:**
_____ Individual or Organization	_____ Individual and/or Organization
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip

TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED: (Check all applicable boxes)

___ Discharge Summary ___ Lab Results ___ Progress Notes ___ Other:_____
___ Psychological Testing ___ Complete Mental Health Record ___ Medication Log ___ Alcohol/Drug Treatment

FOR THE PURPOSE OF:

___ Continuity of Care ___ Transfer of Care ___ Other_____
___ Disability Determination ___ Worker's Comp Claim ___ Court Case ___ Personal

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION – I understand that 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.

POTENTIAL FOR RE-DISCLOSURE - I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy standards.

RIGHT TO WITHDRAW THIS AUTHORIZATION: I understand that written notification is necessary to cancel this authorization. Unless otherwise revoked, this authorization will expire on the following date:

THIS AUTHORIZATION IS EFFECTIVE UNTIL:_____
If no date is listed, this authorization will expire in one year.

_____ Date:_____
Client Signature (14 years and older)

_____ Date:_____
Personal Representative Signature (State Relationship)