Pathway to Wellness
Community Clinic

560 4th Street, Prairie Du Sac, WI 53578
608.643.3663 • fax 608.370.8177 • pathwaytwcc.com

AUTHORIZATION FOR DISCLOSURE OR EXCHANGE OF CONFIDENTIAL MEDICAL RECORDS

PATIENT INFORMATION

Name:	DOB:	Phone:
Address:	City, State, Zip:	

I hereby authorize and request Pathway to Wellness Community Clinic SC to:

☐ RELEASE INFORMATION TO: ☐ RECEIVE INFORMATION FROM: ☐ EXCHANGE INFORMATION WITH:

Organization: (ie; Insurance, Physician, Lawyer, Family, Other)			
Address:			Phone:
City:	State:	Zip:	Fax:

PTWCC will send the last year of medical records unless other dates are indicated: _____/_____/_____ to _____/_____/_____

☐ I authorize records to be sent via facsimile, email, verbal, etc. ☐ Verbal Only ☐ See Below for Records Request

Type or extent of Information to be Disclosed or Exchanged: (Check all applicable categories)

A) _____Specific Records as Follows: ☐ Intake Assessments ☐ Psychiatric Evaluation ☐ Treatment Records
☐ AODA Assessment/Treatment Records ☐ Educational Records ☐ Psychological Testing ☐ Evaluation Reports
☐ Billing Information ☐ Appointments ☐ Other: _____

B) _____Complete Copy of all Records: Include Psychotherapy Notes: ☐ Yes ☐ No

Purpose of Disclosure or Exchange: (Check all applicable categories)

☐ Further Medical Care ☐ Vocational Rehabilitation ☐ Payment of Insurance Claim ☐ Coordination of Treatment
☐ Psychotherapeutic Treatment ☐ Legal Investigation ☐ Psychological Evaluation ☐ Disability Determination
☐ Coordination with School ☐ Request of Client ☐ Other: _____

☐ Do NOT Include Future Records

I understand this authorization is in effect for one year or until: _____/_____/_____ unless otherwise revoked through written notice. In accordance with the specifications listed, I authorize the disclosure or exchange of my records pertaining to mental health records, alcohol and drug treatment, AIDS or AIDS related illness, and/or HIV test results. By signing this authorization, **I acknowledge that I have read the reverse side** and I release the above institution(s) and/or person(s) from legal responsibilities or liability that may arise from this act.

I hereby consent to and authorize the release of information as described on this form. I may also receive a copy of this consent form. The client or person authorized has a right to inspect and upon payment of usual fee, receive a copy of the material to be disclosed. I understand that I am under no obligation to sign this form and that treatment will not be denied if I refuse to sign this authorization. WI statutes 252.15 (HIV) and 51.30 confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Part 160 and Subparts A and E of 164 require patient authorization to disclose health information to payment purposes. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining my authorization. The patient has the right to withdraw this authorization for disclosure or exchange at any time.

Signature of Client/Patient:_____Date:_____
AND/OR (Clients 14-17 must sign along with parent/guardian signature)
Signature of Authorized Person:_____Date:_____

Printed Name of Authorized Person:_____
Patient is: ☐ Minor ☐ Incompetent ☐ Incapacitated ☐ Deceased

State **legal authority** if signed by someone other than the client: (May Require Proof)
☐ Legal Guardian ☐ Parent of Minor ☐ Power of Attorney ☐ Health Care Agent
☐ Personal Representative of Deceased ☐ Other: _____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Pathway to Wellness Community Clinic SC, honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, PTWCC may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Pathway to Wellness Community Clinic SC, 560 4th Street, Prairie Du Sac, WI 53578.

Re-release: If the person(s) and/or organization authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect: You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact your clinician or the office of Pathway to Wellness Community Clinic SC. In accordance with Wisconsin Stature 51.30 [Patient Access s.51.30(4)(d)3], inspection of a record shall be done with a clinician present.

Copying Fees: If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You may be charged for copies you request for other purposes.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are at least 14 years old, you can consent to releasing your own mental health treatment records to others. If you are under the age of 13, your parent or guardian must sign this form for you. There are, however, many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact Pathway to Wellness Community Clinic at 608-643-3663.