Authorization for the Disclosure of Health Information

Patient's Legal Name: _____

Patient's Date of Birth or MRN: _____

I authorize Catalpa Health to (*please "x" one or both*):

☐ **DISCLOSE** written and/or verbal protected health information **TO** the person or organization named below.

☐ **OBTAIN** written and/or verbal protected health information **FROM** the person or organization named below.

_____

Name of Person and/or Organization

_____

Address/City/State/Zip and/or Phone Number

_____

Email Address *(if applicable)* By providing this email address, I give Catalpa Health permission to disclose information via this email address. I am aware there is some level of risk that third parties may be able to read unencrypted emails, and I accept that risk.

I authorize the disclosure of the following specific written or verbal information, including information created after the date of signature but before the date of expiration *(please "x" each box that applies)***:**

☐ Behavioral Health Records ☐ AODA Treatment Records ☐ Completion of behavioral questionnaires

☐ Medical Records ☐ Attendance/Appointment Information ☐ Pupil and Educational Records

☐ Other *(please specify)*:_____

For the following dates: If neither box is checked, information from all dates will be disclosed, including information created after the date of signature but prior to the date of expiration.

☐ All **--- OR ---** ☐ From: _____ To: _____

Disclosure of this information is for the purpose of *(please "x" each box that applies)**:***

☐ Continuation of care ☐ Accompany and schedule appointments ☐ Legal purposes ☐ Personal use

This authorization expires on the following date or when the following event takes place: _____

_____

If no expiration date or event is noted here, this release will expire upon the minor patient's 18th birthday or, if the patient is 18 or older, this release will expire one year from the date of signature.

I acknowledge that I have reviewed the "Your Rights with Respect to this Authorization" section on Page Two of this form.

_____ _____

Print Name of Parent/Legal Guardian Relationship to Patient

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Patient (*if age 14 or older*) Date

Authorization for the Disclosure of Health Information

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have the right to receive a copy of this authorization.

Right to refuse to sign this authorization: You understand that this authorization is voluntary and that you may refuse to sign it. Catalpa Health will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

Right to revoke this authorization: You have a right to revoke this authorization at any time. You must submit written notification of your desire to revoke this authorization to Catalpa Health, Attn: Medical Records, 4635 W. College Ave, Appleton, WI 54914. You should be aware that your withdrawal will not be effective until received by Catalpa and will not be effective regarding the uses or disclosures made prior to Catalpa's receipt of your revocation.

Right to inspect or receive a copy of the information: You have a right to review and/or request a copy of the information you authorized to be used or disclosed by this authorization as required under Wis. Admin. Code DHS ss. 92.05 and 92.06. There may be a charge for these copies as permitted by Wis. Stat. § 146.83 (3f) (c) 2. You may arrange to inspect your file or obtain copies of this information by contacting Catalpa.

Prohibition on re-disclosure: Information disclosed via this authorization may potentially be re-disclosed by the recipient and may no longer be protected by federal and state privacy and confidentiality rules.