NorthLakes COMMUNITY CLINIC

888.834.4551

nlccwi.org

HEALTH INFORMATION RELEASE

1. Patient Personal Information **Today's Date: ____/____/_____**

Patient Legal Name:_____

(Last) (First) (Middle Initial)

Maiden or Previous Name: _____ DOB: ____/____/_____

Patient's Phone Number: (____) _____-_____ Release paper records now? Yes ☐ No ☐

PLEASE NOTE: With this release of information, you are giving permission to share your health records as specified:

2. I hereby authorize/request NorthLakes Clinic to:

Please check all that apply:

❒Release To

❒Receive From

❒Verbal Only

Name: _____

Address: _____

City: _____State:_____

Phone: (____) _____-_____

Fax: (____) _____-_____

3. For the purpose of:

☐Litigation ☐Disability

☐School ☐Work Comp

☐Self/Personal

☐Transfer Care

☐Other (Specify):

_____

_____

_____

4. Please indicate the type of information you authorize for release:

Date Range: _____to_____

❒History & Physical

❒Psychological Testing

❒Progress Notes

❒Diagnosis Test Reports

❒Lab Reports/Pathology

❒Evaluation/Assessment

❒HIV/AIDS

❒Other:_____

❒Entire Medical File

❒Entire Dental File

❒Entire Mental Health File

❒Entire Psych Med Management File

❒Entire Substance Use Disorder File

❒Discharge Summary

❒Sexually Transmitted Disease (STD)

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 understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosures. I understand that the information in my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychiatric management, behavioral and mental health services, and treatment for alcohol and drug use through NorthLakes general provision of health care. NorthLakes employs certain staff members who provide substance use disorder diagnoses, treatment, or referral for treatment through NorthLakes Recovery Program. I understand records created as part of this program are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and/or HIPAA 45 CFR, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, I understand that this consent form does not apply to my records that do not identify me, directly or indirectly, as an individual participating in a program for substance use disorders. I understand that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorized form as required ss. DHS 92.05,92.06, and 94.05. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I can do so in writing or verbally. However, it is highly recommended to send a written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5._____

Date Signature of ☐Patient ☐Parent ☐Legal Guardian ☐Authorized Legal Representative

_____

Date Signature of ☐Patient ☐Parent/Guardian (if patient is 14+years of age, both patient and parent/guardian must sign)

This authorization will expire one year from the above date unless I specify an expiration date:____/_____/_____