NorthLakes COMMUNITY CLINIC

888.834.4551
15735 Highway 63 N
Hayward, WI 54843
nlccwi.org

Release of Information

☐ Please fax to 715-318-5644 ☐ For urgent requests requiring a response within a week, please fax to 715-318-5635

1. Personal Information

Please include date of birth

Patient Legal Name _____
Date of Birth _____
Patient Maiden/Previous Name _____
Phone number _____

2. Release Purpose

Please mark all that apply

☐ Continued Care ☐ Disability
☐ Legal ☐ School ☐ Transfer Care
☐ Work Comp ☐ Self/Personal
☐ Other (Please Specify) _____

3. Release FROM Who has the information you want released?

Name/Organization: _____ Phone: _____ Fax: _____
Street Address: _____ City: _____ State: _____ ZIP: _____

4. Release TO Where do you want the records sent to? Complete address is required

Name/Organization: _____ Phone: _____ Fax: _____
Street Address: _____ City: _____ State: _____ ZIP: _____
Email address: _____ (*NorthLakes will use encrypted email for security purposes)*

5. Release Type ☐ Release Records ☐ Verbal Communication

6a. Information to be released:

For continued care the last 2 years of records will be sent unless a different time frame is specified.

Health Records

DATE RANGE Start Date: _____
End Date:_____

☐ Progress Notes
☐ Lab Reports/Pathology
☐ Medication List
☐ Radiology Reports
☐ Radiology Images
☐ HIV/AIDS
☐ Sexually Transmitted Disease (STD)
☐ Entire Medical File
☐ Entire Dental File (including images)
☐ OT/PT/ST Evaluation and Plan of Care
☐ Other:_____

6b. Information to be released:

Mental Health, Substance Use Disorder, Psychiatric Medication Management Dates Required

Mental Health/Substance Use Treatment/Psychiatry Records

REQUIRED
DATE RANGE Start Date: _____
End Date:_____

☐ YES, please include records created after date of signature

Mental Health:
☐ Progress Notes ☐ Assessment/Evaluation
☐ Discharge Summary ☐ Entire File

Substance Use Treatment:
☐ Progress Notes ☐ Assessment/Evaluation
☐ Discharge Summary ☐ Entire File

Psychiatry:
☐ Progress Notes ☐ Assessment/Evaluation
☐ Discharge Summary ☐ Entire File

Other:_____

By signing this authorization I understand that:

- The disclosure of this health information is voluntary and I may decline to sign this authorization.
- This authorization will expire one year from my signature date unless I revoke it.
- NorthLakes Community Clinic will not condition treatment on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- 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 substance abuse.
- Records created as part of Substance Abuse treatment cannot be disclosed without my written consent Per 42 CFR Part 2 and/or HIPAA 45 CFR
- I have a right to request a copy of the signed authorization and to inspect and receive a copy of the information disclosed.
- This authorization may be revoked at any time by providing written notice of revocation to NorthLakes Community Clinic, except when information has already been released in response to this authorization. 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.

_____
Date Patient Signature

_____
Date Parent/Guardian Signature

For Substance Use Treatment patients 12 and older, both patient and parent/legal guardian must sign.

For Mental Health and Psychiatry patients 14 and older, both patient and parent/legal guardian must sign