



Authorization to Release Protected Health Information

Patient Information:

Last Name	Middle Initial	First Name	Former Name(s)	Date of Birth	
Street Address		City	State	Zip	Phone Number

I hereby authorization _____ from Mequon Clinical Associates to
Name of MCA Clinician(s)

Release information to: and/or Obtain information from: (check all that apply)

Agency/Facility/Person	Relationship	Phone Number	Fax Number	
Street Address		City	State	Zip

Information to be Released/Obtained:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Expected Length of Treatment | <input type="checkbox"/> Treatment Progress |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Dates of Service Only | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Records from Inpatient Stay | <input type="checkbox"/> Diagnosis/Assessment | <input type="checkbox"/> Referral Letter |
| <input type="checkbox"/> Clinical Summary of Care | <input type="checkbox"/> Psychological Evaluation/Testing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> Treatment Plan | |

Purpose of Disclose (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Case Management (including reimbursement and processing of benefits | <input type="checkbox"/> case collaboration |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Legal | <input type="checkbox"/> Other: _____ |

Authorization

Check one of the following:

- This release is in effect until it is revoked.
 This release is in effect until from _____ to _____
(date) (date)

By signing this form, I understand that the information may include genetic testing, diagnosis and/or prognoses related to physical or mental health disorders, including treatment of alcohol and/or drug abuse, and HIV results.

I understand I am voluntarily signing this authorization. I understand my consent may be revoked by me at any time by written notification to the Clinic Director and/or clinician. I understand that any information released prior to a request to revoke permission cannot be retrieved.

Signature of Patient

Signature of Legal representative

Date