Family Service Madison
128 East Olin Avenue, Suite 100, Madison, WI 53713
(608) 252-1320 FAX: (608) 252-1333

Authorization to Use and Disclose Information

HIPAA and MH Regulations Compliance Program Form

I am completing this two-page form to allow the use and sharing of Protected Health Information (PHI). I hereby authorize Family Service Madison and its employees to: **o-Obtain o-Disclose o-Exchange** ***personal and confidential information regarding:***

Last Name(s)	First Name	MI	Other identifying Names	Date of Birth **and/or**	Social Security #
1.					
2.					
3.					
4.					

I authorize the above mentioned personal and confidential information to be released to and/or obtained from the following persons or agency:

Name: _____ Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The Information I allow to be disclosed: (make sure to check all that apply.)

- ☐ Mental Health Records including: progress, diagnosis, observations, prognoses, recommendations, admission and discharge summaries
- ☐ Psychiatric Evaluation/Consultation Records/ Psychological Medication (current and history)
- ☐ Social, family, educational and vocational histories
- ☐ Information about how the client's condition(s) affects or has affected his/her ability to work, and/or complete tasks or activities of daily living.
- ☐ AODA-related information
- ☐ HIV-related information
- ☐ Any payments, billing and insurance records, which may include P.H.I., requested by these agencies.
- ☐ Confirmation of my appointments/schedules
- ☐ Other: _____

☐ Specific Information I do not want to be disclosed: _____

The Purpose of This Disclosure Is:

- ☐ Mental Health Evaluation and Treatment
- ☐ Psychiatric Treatment
- ☐ Coordination of Treatment
- ☐ Disability Determination
- ☐ Legal Procedure
- ☐ Other_____
- ☐ To allow Family Service Madison to confirm and collect payments of my Mental Health insurance benefits

I understand that this authorization is in effect for one year ***or*** *to:_____, unless otherwise revoked through written notice. (Directions on backside of this form #1)*

By signing this authorization, I/We acknowledge that I/We have read the reverse side and I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. ***(HIPAA compliance 4/03)***

Client Signature(s) (14 or older)_____

_____

_____ **Date:**_____

Parent or Legal Guardian Signature_____ **Date:**_____

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1. I understand that I can revoke or cancel this authorization by sending a letter or by coming into Family Service Madison and signing a revocation request to the Privacy Officer at Family Service Madison. The only exception is to the extent that information has been disclosed prior to a written revocation. (HIPAA compliance 4/03)

2. I am informed and authorize that my mental health and/or billing records may be released using any of these formats: Written, Verbal, Voice mail, Electronic mail and/or Billing, or Faxed communications. (HIPAA compliance 4/03)

3. I understand I am under no obligation to sign this form. However, there are certain circumstances as permitted under applicable law where treatment may be denied unless there is a signed release. (condition statements) (HIPAA compliance 4/03)

4. I understand that I must comply for my insurance to be billed. If I refuse to sign, I must pay in full personally for any and all services. (condition statements) (HIPAA compliance 4/03)

5. I understand that any information released to Family Service Madison by other agencies will not be disclosed by Family Service Madison and I must contact these agencies to obtain these documents. I may also receive a copy of this form when requested.

6. Family Service Madison policy follows the Ownership of the Mental Health Record WI stat. 146.38 which identifies that the "Original record is the property of the facility. Patient has no right to the original, except that a patient may retrieve the original from a practitioner who dies as a alternative for destruction." (WI/Federal statute 146.38)

7. I understand disclosure of my information may contain a fee to another agency or myself of which I authorize. ($.50/pg 4/03) (HIPAA compliance 4/03)

All matters relating to client records are considered privileged and confidential and are treated as such by the staff of Family Service Madison. Information regarding such matters cannot be given without the consent of the client unless evidence of child abuse exists, a life-endangering situation exists, or social workers are subpoenaed to testify in court. (Wis. Statutes: 48.981; 51.15; 905.) The client has a right to inspect and receive a copy of material to be disclosed as required under SS.HSS 92.05 and 92.06.

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"According to the HIPAA regulations those who receive Personal Health Information (PHI), are required to make significant efforts to assure the privacy of this PHI. This requires that you have put in place the appropriate administrative procedures, physical safeguards, and technical security services to maintain the integrity, confidentiality and availability of PHI and to prevent unauthorized access to the PHI". Family Service Madison has every confidence these are in place to follow HIPAA regulations as of April 2003.