**Regent Mental Health Group**
**Authorization to Release Information**

**Client Name**: _____ **Date of Birth**: _____

**I authorize**: Regent Mental Health Group
6515 Watts Rd, Ste 206
Madison, WI 53719-2726
Phone: 608-238-5826
Fax: 608-238-1221

**To:** _____Release and Obtain _____Obtain _____Release

**To/From:** _____
(Doctor, Clinic, Hospital or Person(s) Name)

_____
(Address)

_____
(City, State and Zip)

_____
(Phone Number) (Fax Number)

**The following specific information or reports from my records:**

_____Mental Health, Medical & Alcohol/Drug, HIV/AIDS _____Mental Health
_____Alcohol & Drug _____Medical
_____Other_____

**The purpose of the disclosure is:**

_____Coordination of Care _____FMLA Form _____Legal
_____Application for Insurance _____Patient Use _____Disability Determination
_____Other _____

*I am aware that treatment services are not contingent upon the decision concerning the release of information.
*I hereby release the above institution and/or person(s) from legal responsibilities or liability that may arise from this act.
*A copy of this release shall be as valid as the original.
*This consent may be revoked by me at any time except to the extent that action has been taken in reliance thereon. This consent unless revoked earlier shall be valid for one year. I have read additional information regarding Disclosure of Information on the reverse side of this form.

**Client Signature**:_____ **Date**:_____
(if required)

**Parent/Guardian**:_____ **Date**:_____

**Witness Signature**:_____ **Date**:_____

**Signature of Revocation**:_____ **Date**:_____

This authorization form is intended to be in conformance with Sections 49.53, 51.30 (2), and 146.82 Wisconsin Statues and Title 45 Code of Federal Regulations Section 205.50.

**FOR OFFICE USE ONLY: _____Release to _____Obtain from _____Verbal Communication**

# Additional Information regarding Disclosure of Information

Regent Mental Health Group honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

**No Obligation to Sign**
You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, any therapist or physician may not refuse to provide you treatment if you refuse to sign this form.

**Revocation**
You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to RMHG 6515 Watts Road, Suite 206, Madison, WI 53719.

**Re-release**
If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws and those people may be permitted to re-release your medical information without your prior permission.

**Right to Inspect**
You have the right to inspect or copy the medical information whose disclosure you are authorizing with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Office Manager of Regent Mental Health Group.

**Copying Fees**
If you are requesting disclosures/release of information to other hospitals, clinics or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

**Signatures**
Generally, all patients 18 years of age or older, must sign for the release of their records. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rules does not apply:

a) The patient is incompetent.
b) The patient is disabled or cannot sign the form.
c) The patient is deceased. (The surviving spouse or legal representative must sign authorizations releasing records of the deceased patient).

**Patients less than 18 years of age must sign for release of their medical records when**:

a) The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism or drug dependence.
b) The patient's records for release include an abortion procedure.

*All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release records.