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AUTHORIZATION TO RELEASE MEDICAL RECORDS:

SECTION 1: PATIENT INFORMATION

Name- Last, First, MI	Date of Birth
MA Number / Member ID	Phone Number
Street Address	City State Zip

SECTION 2: PARTIES INVOLVED IN DISCLOSURE OF RECORDS

I ____, HEREBY AUTHORIZE AND REQUEST:
(Name of Patient or Patient's Legally Authorized Representative)

Marriage & Family Solutions, LLC
7818 Big Sky Drive, Suite 101
Madison, WI 53719—2840
P: 608-203-6267 **F:** 608-203-6696

☐ **TO RELEASE TO:**
☐ **TO RECEIVE FROM:**
☐ **TO RELEASE TO AND RECEIVE FROM:**

Organization/Individual: ____

Address: ______________________________ ________________ ____ ______

Phone: ______________________ **Fax:** ______________________

SECTION 3: INFORMATION TO BE DISCLOSED

☐ Complete Medical Record:
from ____/____/________ to ____/____/_______

☐ Progress Notes

☐ Discharge Summary

☐ Lab/Pathology Results

☐ Clinical Summaries

☐ Most Recent Medication List

☐ Other: ______________________________

SECTION 4: PURPOSE FOR DISCLOSURE

☐ Continued Medical Care

☐ Coordination of Care

☐ Disability Determination

☐ Vocational Rehabilitation

☐ Insurance Processing

☐ Legal

☐ To Confirm Treatment/Diagnosis

☐ Patient Use

☐ Other: _________________________

SECTION 5: EXCLUDING SPECIFIC HEALTH INFORMATION
I understand that my medical record being released as authorized above may contain information that confirms diagnoses of and/or treatment for: alcohol and other drug, mental illness, psychiatric treatment, AIDS or AIDS-related illness, HIV test results, sexually transmitted diseases, and/or developmental disabilities, unless I limit this disclosure to ***EXCLUDE the following information from the records released:*** ____

SECTION 6: UNDERSTANDING MY RIGHTS

- I understand signing this authorization is voluntary and my refusal to sign will not affect my eligibility to obtain health care benefits (treatment, payment or enrollment).
- I understand that a photocopy of this authorization shall be considered valid as the original.
- I am aware I have the right to inspect or receive a copy of the health information to be used or disclosed and this authorization.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected by applicable deferral and state privacy laws.
- ***I may revoke this authorization through written notice*** to Marriage & Family Solutions, LLC at any time *(except for information already released as a result of this authorization).*
- Unless revoked, this authorization will remain in effect until the expiration indicated below:

☐ Authorization expires on: _____/_____/_________ ☐ Authorization expires 12 months from the date I sign this authorization
☐ Authorization should remain valid and on file until I revoke

SECTION 7: SIGNATURE

Signature of Patient ______________________________________**Date:** ________________

If signed by legal representative please indicate Relationship: ________________________________

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Spouse of Deceased ☐ Personal Representative of Deceased
☐ Health Care Agent: ________________________ ☐ Other ________________

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased