



# Informed Consent for Release of Confidential Information

Ph.: 920-750-7000 Fax: 920-882-0857

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MR# \_\_\_\_\_

I authorize Catalpa Health to DISCLOSE TO / OBTAIN FROM (circle one or both):

Relationship: \_\_\_\_\_

(Name of Person and/or Organization)

(Address/City/State/Zip)

THE FOLLOWING WRITTEN OR VERBAL INFORMATION FOR THE FOLLOWING DATES:

From: Patient's date of birth To: Patient's 18<sup>th</sup> Birthday

**THIS CONSENT EXPIRES UPON THE PATIENT'S 18<sup>TH</sup> BIRTHDAY UNLESS INDICATED OTHERWISE BELOW:**

- Authorization expires as of (Date) \_\_\_\_\_
- Authorization expires when the following action takes place: \_\_\_\_\_

\*Disclosure of this information is for the purpose of (select all that apply):

- Continuation of care
- Accompany and schedule appointments
- Legal purposes
- Personal use

\*The following specific written or verbal information is being requested, including information created after the date of signature but before the expiration (**PLEASE "X" EACH BOX APPLYING TO REQUEST**):

- Diagnostic Evaluation/Intake Assessment
- Diagnosis
- Pupil and Educational Records
- Progress Notes
- Medications/Dosage Instructions
- Completion of Behavioral Questionnaires
- Discharge Summary
- Neuro/Psychological Evaluation
- Labs/Imaging Results
- Treatment Plan/Goals
- Attendance/Appointment Information
- Other (please specify): \_\_\_\_\_

## YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

**Right to receive a copy of authorization:** You have a right to receive a copy of this authorization.

**Right to refuse to sign this authorization:** You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

**Right to withdraw this authorization:** You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Catalpa and will not be effective regarding the uses or disclosures made prior to cancellation.

**Right to inspect or receive a copy of the information:** You have a right to review and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization as required under Wis. Admin. Code DHS ss. 92.05 and 92.06. There are certain legal restrictions to this that may be applicable, for example, a minor's records cannot be released to parents who have been denied physical placement of the minor. You may arrange to inspect your file or obtain copies of this information by contacting Catalpa.

**Prohibition on re-disclosure:** The information and records being requested are protected under federal and state confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is permitted by written consent or as otherwise permitted by law. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by federal and state privacy and confidentiality rules.

I further acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

## PERSON AUTHORIZED TO SIGN FOR PATIENT

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

AND/OR

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patients 14 years & older only)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

This informed consent was revoked as of \_\_\_\_\_ (Date) \_\_\_\_\_ (Signature)