Informed Consent for Release of Confidential Information

Phone: 920-750-7000 Fax: 920-882-0857

Catalpa Health
Mental Health & Wellness For Kids
Ascension Wisconsin • Children's Wisconsin • ThedaCare

Patient Name: _____ DOB: _____MR#_____

I authorize Catalpa Health to ☐ DISCLOSE TO/ ☐ OBTAIN FROM (PLEASE "X" ONE OR BOTH):

_____

(Name of Person and/or Organization)

_____

(Address/City/State/Zip) *(Phone Number)*

THE FOLLOWING WRITTEN OR VERBAL INFORMATION **(PLEASE "X" BOX APPLYING TO REQUEST)**:

Dates of Service: ☐ from: Date of Birth_____ to: Expiration **Below**___

--- OR---

☐ from: _____ to: _____ (fill in date range)

***If nothing is checked**, all dates will be covered through expiration, including information created after the date of signature but before the expiration*

☐ 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 ☐ Behavioral Health Records ☐ Attendance/Appointment Information
☐ Other:_____

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

☐ Continuation of care ☐ Accompany and schedule appointments
☐ Legal Purposes ☐ Personal use

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 understand that my medical records may include information related to mental/behavioral health, alcohol and drug abuse, sexually transmitted diseases and HIV/AIDS

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

THIS CONSENT EXPIRES UPON THE PATIENT'S 18TH BIRTHDAY UNLESS INDICATED OTHERWISE BELOW:

☐ Authorization expires as of (Date)_____

☐ Authorization expires when the following action takes place:_____

PERSON AUTHORIZED TO SIGN FOR PATIENT

Print Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

AND/OR

Patient Signature: _____Date: _____
(Patients 14 years & older only)

☐ This informed consent was revoked as of _____(Date)_____(Signature)

Revised 04/15/2021 JDB (A PHOTO COPY OF THIS CONSENT IS AS VALID AS THE ORIGINAL)