❒ **Columbia St. Mary's Hospital Milwaukee (Medical Record Dept)** ..... Telephone: (414) 291-1112
2323 N. Lake Dr., Milwaukee, WI 53211 ..... Fax: (414) 291-1113

❒ **Columbia St. Mary's Hospital Milwaukee (Inpatient Unit)** ..... Telephone: (414) 291-5520
2323 N. Lake Dr., Milwaukee, WI 53211 ..... Fax: (414) 291-5521

❒ **Columbia St. Mary's Hospital Milwaukee (Intensive OP Services)** ..... Telephone: (414) 291-1620
2323 N. Lake Dr., Milwaukee, WI 53211 ..... Fax: (414) 291-1924

❒ **Columbia St. Mary's Hospital Ozaukee (Medical Record Dept)** ..... Telephone: (262) 243-7368
13111 N. Port Washington Rd., Mequon, WI 53097 ..... Fax: (262) 243-7329

❒ **Columbia St. Mary's Hospital Ozaukee (Inpatient Unit)** ..... Telephone: (262) 243-7388
13111 N. Port Washington Rd., Mequon, WI 53097 ..... Fax: (262) 243-8380

❒ **Huiras Center (Intensive OP Services)** ..... Telephone: (262) 241-6127
13111 N. Port Washington Rd., Mequon, WI 53097 ..... Fax: (262) 241-6132

❒ **Other**

AUTHORIZATION FOR USE / DISCLOSURE OF BEHAVIORAL MEDICINE INFORMATION

MR #:

ID Verified:

_____ / _____ _____
(Patient Name) (Previous Name) (DOB)

Address, City, State, Zip _____

❒ I hereby authorize the above noted facility to release records of my treatment (i.e. send my records) to the person/institution named below: **OR**
❒ I hereby authorize the above noted facility to obtain records of my treatment from (i.e. receive my records) from the person/institution named below:

Name _____ Phone # _____ Fax # _____

Address, City, State, Zip _____

The purpose for releasing /obtaining these records is: ❒ To aid in the continuity of my care **OR** ❒ Specify _____

I understand that the information may include diagnosis, prognoses, and/or treatment for physical and emotional illness, including treatment of alcohol and/or drug abuse and HIV results. Records of child and adolescent patients may include reference to parental emotional illness, including the treatment of alcohol and drug abuse.

The specific and relevant information to be released or obtained:

❒ Discharge Summary
❒ History & Physical
❒ Verbal Information
❒ Psychiatric Evaluation
❒ ER Report
❒ Indication _____
❒ Referral letter & Transfer Form
❒ Psychosocial & Chemical Hx
❒ Free of Communicable Disease
❒ OP Assessment/Evaluations
❒ Psychological Evaluation/Testing
❒ Aftercare Plan
❒ Lab Data
❒ X-Ray Reports
❒ Obtain attendance info for initial aftercare appointment

Child & Adolescent Forms:

❒ Patient Cover Letter to School
❒ M-Team Reports
❒ Immunization Records
❒ Academic, attendance, behaviors info

Treatment Time Period (list dates): _____

I understand that the above noted facility will not condition treatment or payment on the signing of this authorization except where the provision of healthcare is solely for the purpose of creating health care information for disclosure to a third party. I have the right to revoke this authorization (by written notification only to the Operations Manager in the Medical Record Department) except to the extent that information was released, as authorized, prior to notice of the revocation. I understand that I do not have the right to revoke this Authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. This consent will remain in effect until the following date or event _____ and in all cases expires in one (1) year.

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (§51.30) confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand I may inspect and receive a copy of the disclosed information. I have read all of the above and understand the nature of this release.

CHECK ONE OF THE FOLLOWING:

❒ I am the patient.
❒ I am the legal guardian of the above named patient (proof of guardianship required).
❒ I am the parent of the above named minor child and I represent that I have not been denied access to my child by a court of law and/or denied periods of physical placement with my child.
❒ I am the next-of-kin of the above named deceased patient (proof of death required).
❒ I am the executor/personal representative of the estate of the above named deceased patient (proof required).
❒ I am the above named patient's Durable Power of Attorney for Healthcare Agent (proof and activation of DPOA required).

Date: _____ Time _____ Signature _____

Date: _____ Time _____ Witness _____

THE HOSPITAL RESERVES THE RIGHT TO CHARGE FOR COPYING MEDICAL RECORDS

IF THIS IS A 2-PLY FORM: BOTH SUFFICE AS ORIGINAL **FAX IS AS GOOD AS ORIGINAL**

Copy will be provided to patient when authorization is requested by CSM or upon request by patient.