



Adams-Friendship Area School District
201 West 6th Street, Friendship, WI 53934
Phone: 608-339-3213 ▪ Fax: 608-339-6213

Patient Release of Information Consent Form

Last Name: _____ First Name: _____ DOB: _____

I, hereby authorize:

Name/Agency:

Adams-Friendship Area School District
201 W. 6th Street, Friendship, WI 53934
Phone: 608-339-3213 Fax: 608-339-6213

To: ☐ Release To ☐ Obtain From ☐ Exchange ☐ Verbal Exchange

Record Holder Name/Agency: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Check below information to be released:

- | | |
|--|---|
| ☐ Intake Summary | ☐ Legal Information |
| ☐ Social History | ☐ Probation/Parole |
| ☐ Mental Health Assessment | ☐ Medical Record |
| ☐ Substance Use Assessment | ☐ Prescriptions |
| ☐ Psychiatric Evaluation | ☐ X-Rays/Labs |
| ☐ Psychological Testing | ☐ School Attendance Records |
| ☐ Consultation | ☐ School Discipline Records |
| ☐ Progress Notes/Case Notes | ☐ Special Education Records |
| ☐ Progress Report/Case Report | ☐ Financial Information |
| ☐ Treatment Plan | ☐ Discharge Summary |
| ☐ Treatment Diagnosis | ☐ Guardianship/Placement Records |
| ☐ Individual Behavior Plan | ☐ Community Based Programming |
| | ☐ Other (please specify): _____ |

Purpose of Release

- | | | |
|--|--|---|
| ☐ Behavioral Health Services | ☐ Case Management | ☐ Continuity of Care |
| ☐ Community Resource Connection | ☐ Insurance | ☐ Other: _____ |

Redisclosure notice to patient: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of

this authorization may no longer be protected by the federal privacy standards if such person(s) and/or organizations(s) re-disclose my health information.

Disclosure notice to recipients of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

- **Right to receive a copy of this authorization:** I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- **Right to refuse to sign this authorization:** I understand that I am under no obligation to sign this form.
- **Right to withdraw this authorization:** I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Pupil Services Department. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form.
- **Right to inspect a copy of the health information to be used or disclosed:** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Pupil Services Department.
- **Mental health treatment records:** I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

In compliance with Wisconsin law, which requires special permission to disclose otherwise privileged information; I specifically authorize the use and disclosure of my Highly Confidential Information selected above, if any. I have had an opportunity to review and understand the content of this authorization form, including the notices that appear on the back of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Expiration Date: This authorization will remain in effect (check applicable category)

- ☐ From the date this authorization is signed until the day of 20
- ☐ Until I cancel this authorization in writing.
- ☐ Until the following event occurs, specify event:
- ☐ Other:

(Signature of Patient)

Date

(Signature of Parent/Guardian/Authorized Representative)

Relationship to Patient