Madison Mental Health Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
Please read these instructions carefully before completing this form.

When to Use This Form

You must complete this form if you want Madison Mental Health Services and/or Lesa J. Fischer, LCSW to give information about you to someone else (for example, an agent or family member).

Parents or a legal guardian may sign for a minor unless the information being released is about:

- pregnancy,
- sexually transmitted disease,
- alcohol or drug abuse,
- abortion,
- hepatitis B shot, or
- mental illness of a minor.

For these types of records, the minor must sign the authorization.

How to Complete This Form

The *Authorization for Release of Confidential Information* form must be completed and signed by:

- The person whose information will be released, or
- The parent or legal guardian of a minor whose information will be released except as listed above, or
- The personal representative of the person whose information will be released (e.g., power of attorney, conservator, legal guardian, executor).

To complete this form:

- Fill in the name and date of birth of the person whose information will be released.
- Check the type(s) of information you want to be released.
- Fill in the name and address of the person or group who will receive the information.
- State the purpose for this authorization.
- If you are signing on behalf of the patient, please complete the Personal Representative section of the form and include your documentation of legal status, such as Power of Attorney.

Mail or Fax This Form to:

Lesa J. Fischer, LCSW
Madison Mental Health Services
702 North Blackhawk, Suite 104
Madison, Wisconsin 53705
Fax: (608) 231-2334

Note: Under the law, an authorization for use or disclosure of psychotherapy notes cannot be combined with an authorization for use or disclosure of other health care information.

Madison Mental Health Services

Patient-Requested Authorization for Release of Confidential Information

Patient Information
(Person granting release of information)

Patient Name: ____________________

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Date of Birth: ____________________

Patient Address: ____________________

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____

Patient Area Code and Phone Number:

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I authorize Madison Mental Health Services and/or Lesa J. Fischer, LCSW to release the following information:

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Madison Mental Health Services and/or Lesa J. Fischer, LCSW may release this information to:

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Phone/Fax:______________________

Purpose for this Release: ____________

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I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

Services administered by Madison Mental Health Services and/or Lesa J. Fischer, LCSW will not be affected if I do not sign this form.

Right to Revoke
I understand that I may cancel this Authorization in writing at any time by notifying Madison Mental Health Services and/or Lesa J. Fischer, LCSW, but it will not affect any release of information processed before I cancel it.

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here:

____

______________________________ ________________

X Signature of Patient Date

Personal Representative
If this request is by a personal representative on behalf of this patient, complete the following and include your documentation of legal status, such as Power of Attorney.

______________________________ ________________

X Signature of Parent or Other Personal Representative Date

Personal Representative's name (please print):

____

Relationship to patient: ________________________________

Personal Representative's address:

____

____

Personal Representative's area code and phone number: