Red Cliff Community Health Center
88455 Pike Road, P.O. Box 529
Bayfield, WI 54814
Bus: 715-779-3707 Fax: 715-779-3711

SPECIAL AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR ALCOHOL AND OTHER DRUG ABUSE PATIENT RECORDS

I,__________________________________, hereby voluntarily authorize the use or disclosure of my protected health information as described below.

Patient Name______________________________D.O.B.____________________________CHART________________

The use or disclosure is to be made by:	The use or disclosure is to be made to:
Name of Facility:______________________________	Name of Facility:______________________________
Address:_____________________________________	Address:_____________________________________
City/State:___________________________________	City/State:___________________________________

The specific information to be disclosed is as follows:

- ☐ Notes/Record of psychotherapeutic intervention
- ☐ Substance Use Disorders Diagnostic Schedule and/or Alcohol Use Profile
- ☐ BioPsychoSocial Evaluation and/ or Multi-Disciplinary Data Base
- ☐ Psychological Evaluation and/or psychological testing(s), consultation, and/or therapy summaries
- ☐ Psychiatric Evaluation and/or testing(s), psychiatric consultation, and/or therapy summaries
- ☐ Therapist or Counselor Discharge Summary/Aftercare Plan.
- ☐ Other:____
  ____

The purpose or need for this disclosure is to aid in:

- ☐ The continuity of care.
- ☐ Determine eligibility of insurance or other 3rd party coverage
- ☐ Other:____

I understand that authorizing the disclosure of this behavioral health service information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided by Federal and State Laws. I understand that any disclosure of information carries with it the protection of Federal Regulation (42 CFR- Part II) and Wisconsin Statutes 51.30 and 51.61 which prohibit us from making any further disclosure of this information without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for release of medical or other information is NOT SUFFICIENT for this purpose. If I have questions about disclosure of my behavioral health information, I can contact the Red Cliff Community Health Center Medical Records Department.

I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at the Red Cliff Community Health Center. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

This authorization will expire (Date, event, or condition) ____
(One year maximum)

____ ____________________________________
Signature Of Client or Legal Representative **Date**

____ ____________________________________
Parent/Legal Guardian/Authorized Representative **Witness Signature**

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