



NORTHSTAR DAY TREATMENT

6506 Schroeder Road
Madison, WI 53711
PHONE: (608) 270-1960
FAX: (608) 270-1965

1. I, _____,
DOB: _____
Address: _____
City/State/Zip: _____

HEREBY AUTHORIZE

(Circle Choices)

Release Information To:
Obtain Information From:
Exchange Information With:

Contact Information of Authorized Person(s)/Organization(s)

Authorized Person(s) Party	Relationship or Organization
Address	Phone
City, State, Zip	Fax

2. RELEASE OF INFORMATION REGARDING: _____
Print Patient Name and Date of Birth

3. PURPOSE OR NEED FOR DISCLOSURE: (Check Applicable Categories)

- | | |
|--|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Social Security Disability |
| <input type="checkbox"/> Application for Insurance | <input type="checkbox"/> Legal Investigation or Action |
| <input type="checkbox"/> Obtain payment for Insurance Claims | <input type="checkbox"/> Vocational Rehabilitation or Action |
| <input type="checkbox"/> Patient's Request (personal use) | <input type="checkbox"/> Other (Specify): _____ |

*I understand that if the person and/or organization listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, then health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

4. TYPE OF INFORMATION TO BE DISCLOSED: (Complete A and C)

- a. Records Regarding Treatment for: _____
- b. Records from the Time Period: _____
- c. Specific Information Requested: (Please Specify Below)
- | | | |
|--|--|---|
| <input type="checkbox"/> Social History | <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Psychological Assessment |
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluation (diagnosis/prognosis) |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Discharge or After Care Plan | <input type="checkbox"/> Medication Evaluation and Monitoring |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Alcohol/Drug Evaluation/Treatment | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> School Reports | <input type="checkbox"/> Legal Statutes/Offenses | <input type="checkbox"/> Verbal |
| <input type="checkbox"/> Other: | | |

*Information to be released may include psychiatric, developmental, alcohol abuse, drug abuse, HIV test results, AIDS, AIDS related disease diagnosis unless specified.

5. EXPIRATION DATE: This Authorization shall be valid for one year unless otherwise stated or revoked through written notice to medical records department. Alternative date or event if not one year: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be disclosed – I understand that I have the right to inspect or copy health information I have authorized to be used or disclosed by this authorization. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department. Right to receive copy of this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. Right to revoke this authorization – I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or receive a copy of my revocation I may contact the Medical Records Department. I am aware that my revocation 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 already made in reference to this authorization.

6. SIGNATURE OF PATIENT: _____ DATE SIGNED: _____

7. SIGNATURE OF AUTHORIZED PERSON: _____ DATE SIGNED: _____

If signed by other than patient, state relationship and authority to do so:
Legal Guardian _____ Parent _____ Next of Kin _____ Power of Attorney _____