Authorization Form
For the Use and Disclosure of Psychotherapy Notes

University of Wisconsin-Milwaukee
[Covered Department Name and Contact Information]

Patient Name (print): ______________________________

Date of Birth: ______________________________

By signing this Authorization Form, I understand that I am allowing the above-listed Department of the University of Wisconsin - Milwaukee and its designated medical record custodians to use and/or disclose psychotherapy notes documenting a counseling session in which I was treated to the following person(s) or organization(s):

Name of person(s) or organization(s): ______________________________

Street address: ______________________________

City, state and zip code: ______________________________

Telephone number: ______________________________

Facsimile number: ______________________________

Number of additional persons or organizations: __________
If additional persons or organizations, see Attachment.

I specifically authorize the use and/or disclosure of the following Protected Health Information:

- ❑ Psychotherapy Notes: ______________________________
  ____

This Protected Health Information is being used or disclosed for the following purposes:

- ❑ Research: ______________________________
- ❑ Other: ______________________________

I understand that I may revoke this authorization at any time by notifying [insert contact address] in writing of my intent to revoke the authorization. I understand that such a revocation will not have any effect on any information already used or disclosed before the receipt of my written notice of revocation.

Unless earlier revoked, this authorization will expire:

- ❑ Upon my request.
- ❑ At the conclusion of the applicable research study.
- ❑ Other: ______________________________

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

© Board of Regents of the University of Wisconsin System on behalf of the University of Wisconsin—Milwaukee, 2006.

I understand that I may inspect and receive a copy of the information to be used and disclosed pursuant to this authorization form.

I understand that I may refuse to sign this authorization form and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
{Alternative language for research: I understand that if I refuse to allow the use or disclosure of my Protected Health Information for research, I will not be eligible for treatment from [name of Covered Department].}

______________________________________	____________
Signature of patient or parent or legal guardian	Date

____
Printed name of patient

____
Printed name of parent or legal guardian (if applicable)

____
Relationship to patient (if applicable)