Norris Health Center
University of Wisconsin-Milwaukee
P.O. Box 413
Milwaukee, WI 53201

Phone: (414) 229-4716
Fax: (414) 229-4161

INFORMED CONSENT FOR DISCLOSURE OF MENTAL HEALTH INFORMATION

Patient Name _____ Former Name _____
(first name middle initial last name)

Date of Birth _____

1) I authorize the following Health Care Provider:

_____
Disclosing Party's Name (Health Care Provider)
_____
Street Address
_____
City State Zip
Fax: _____

2) To disclose to the following Party:

_____
Receiving Party's Name
_____
Street Address
_____
City State Zip
Fax: _____

☐ **These records are needed for an appointment on _____.**
(Date of Appointment)

3) The Following Information:

	Dates
☐ Psychotherapy Notes	_____
☐ Verbal Discussion Only	_____
☐ Medication Record	_____
☐ Letter re: my mental health condition	_____

4) Disclosure is being made for following purpose:

- ☐ Continuing Care
- ☐ Insurance / Claims
- ☐ Legal
- ☐ Personal Information
- ☐ Appeal for University Withdrawal
- ☐ Other (specify) _____

5) Acknowledgement of Understanding (Initial each line):

___ I understand the expiration date of this authorization is _____ (6 months from signature).
___ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
___ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulation, though in the state of Wisconsin redisclosure is prohibited.
___ By authorizing this use of disclosure of information, there will be no conditions placed on my health care or payment for health care.
___ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
___ I understand that my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified and have the right to request review of any denial of access other than those made in accordance with applicable law.
___ I understand that I may be required to pay the cost of preparing and mailing copies except for the purpose of treatment or payment.

_____ _____
Patient/Legal Representative Signature Date

NHC Staff Only: Received and checked for completeness by: _____ _____ _____
(Date) (Initials) (MRN)
Release Date _____ # Pgs _____ Certified: Y N Via: Mail Fax Pick Up Intercampus Mail

Completed by Initials_____ Rev 1/11; 6/08