

Authorization for Release of Information
Madison Psychiatric and Psychological Services
702 N. Blackhawk Avenue, Suite 100
Madison, Wisconsin 53705
Phone: (608) 663-5926

1 I hereby authorize: _____ of (M.P.P.S.)

2 (Check one or both) Name and/or agency: _____
 to obtain from: Street address: _____
and/or City/state/zip code: _____
 to release to:

3 Information from the records of: _____
(Client Full Name) (Date of Birth)

4 Type(s) of treatment information to be disclosed: Medical Mental Health
 HIV Alcohol/Drug Abuse
Specific information to be disclosed: _____

5 Purpose or need for disclosure: _____

6 Unless expressly revoked in writing, this authorization expires on the following date: ___/___/___
(mo./day/year)

7 I understand that my records are protected under State and Federal regulations governing confidentiality:
Mental Health—Sec. 51.30, Wis. Stats. & HSS 92, Wis. Admin. Code
Alcohol & Other Drug Abuse—42 CFR, Part 2, Sec. 51.30, Wis. Stats. & HSS 92, Wis. Admin. Code
I understand that I have the right to inspect and receive a copy of the material to be disclosed [HSS 92.05 and 92.06] and that information received cannot be disclosed further without my written consent unless otherwise provided for in the regulations. I understand that M.P.P.S. can not condition treatment or payment for services based on the provision that I authorize this disclosure. I further understand that I have the right to refuse to sign this authorization.
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and that the information may not be protected by confidentiality rules.
Further, I understand that this consent to disclose may be revoked by me in writing at any time except to the extent that action has already been taken.

(Client Signature)

(Date signed)

OR: (Signature of Person Authorized to Consent)

(Relationship to Client)

(Date signed)