# NORTHSTAR DAY TREATMENT

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

1. I, _____, HEREBY AUTHORIZE

DOB: _____
Address: _____
City/State/Zip: _____

**(Check All Choices That Apply)**
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)

☐ Further Medical Care
☐ Application for Insurance
☐ Obtain payment for Insurance Claims
☐ Patient's Request (personal use)
☐ Social Security Disability
☐ Legal Investigation or Action
☐ Vocational Rehabilitation or Action
☐ 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)

☐ Social History
☐ Admission Summary
☐ Treatment Plan
☐ Progress Notes
☐ Treatment Summary
☐ Discharge Summary
☐ Discharge or After Care Plan
☐ Alcohol/Drug Evaluation/Treatment
☐ Psychological Assessment
☐ Psychiatric Evaluation (diagnosis/prognosis)
☐ Medication Evaluation and Monitoring
☐ Medical Reports
☐ School Reports
☐ Legal Statures/Offenses
☐ Verbal
☐ 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 ☐