



Operated by Beloit Memorial Hospital

1969 West Hart Road, Beloit, WI 53511
608.364.5686 (Phone) 608.363.5756 (Fax)
beloitmemorialhospital.org

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

PATIENT INFORMATION

LAST NAME FIRST MIDDLE DATE OF BIRTH

STREET ADDRESS CITY, STATE, ZIP PHONE NUMBER

I HEREBY AUTHORIZE AND REQUEST:

Counseling Care Center TO RELEASE TO ORGANIZATION/INDIVIDUAL

1969 W. Hart Road TO RECEIVE FROM STREET ADDRESS

Beloit, WI 53511 TO RELEASE TO AND RECEIVE FROM CITY, STATE ZIP

PHONE FAX

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

Mental Health HIV Status Alcohol and/or Drug Abuse

Specific Information Requested:

Psychosocial History Psychiatric Evaluation Appt./Confirmation/Referral
Physical Examination Psychiatric Treatment Notes Discharge Summary
Treatment Plan Psychotherapy Treatment Notes School Records
Physician's Orders AODA Assessment Lab Data
Psychological Evaluation AODA Treatment Notes Other

Service dates to be released: From to

Purpose for need of disclosure: (please check all that apply)

Further Medical Care Coordinating Care for Dependent/Spouse
Insurance Claims Resolution Other

I understand that I have the right to copy and inspect the information that is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness.

It is further understood that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing. I understand that the withdrawal will not apply to information that has already been released in response to this authorization, and that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following day or event: . If I fail to specify an expiration date, this authorization will expire in six months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I may experience consequences for not signing this authorization if referred from a mandatory agency (i.e., employer, courts).

I understand that I have the right to have a copy of this signed consent.

Signature of Patient (Includes minors 14 years of age and over)

Date Signed

Signature of Parent/Guardian/Personal Representative (Relationship)

Date Signed



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Signature of Witness

Date Signed