Release of Information Form

I, the undersigned, hereby authorize the disclosure and exchange of the records and information specified below concerning:

NAME:_____ whose date of birth is_____ by the following:

TO/FROM: **Inclusa** TO/FROM:_____

Office Address: _____

_____ _____

TYPE OF INFORMATION TO BE RELEASED: ☐ Verbal ☐ Written ☐ Electronic

INFORMATION TO BE RELEASED:

- ☐ Intake/Initial Assessment
- ☐ Medical Evaluations/H & P/Records
- ☐ Education Evaluations/Records
- ☐ Mental Health Services
- ☐ Staffing/Progress Notes
- ☐ Laboratory Reports
- ☐ Discharge Summary
- ☐ LTC Functional Screen
- ☐ Medications
- ☐ Treatment Plan/Reviews
- ☐ Social History
- ☐ Other (Specify)_____

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

- ☐ Continuity and Coordination of Care
- ☐ Educational Planning
- ☐ Medical Care
- ☐ Legal Investigation or Action
- ☐ Personal
- ☐ LTC Functional Screen
- ☐ Other (Specify)_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization: I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that Inclusa cannot condition treatment, or payment on my decision to sign this authorization.

Right to Withdraw This Authorization: I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Privacy Officer. Please mail your request to Inclusa, Attn: Privacy Officer, 3349 Church Street, Stevens Point, WI 54481. I understand that my withdrawal will not be effective until received by the Privacy Officer and will not be effective regarding the uses and/or disclosures of my health information that Inclusa has made prior to receipt of my withdrawal statement.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect the health information or, for a fee, obtain a copy of the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect and/or obtain copies of my health information by contacting my care team or Privacy Officer at (715) 204-1734.

RE-DISCLOSURE NOTICE: I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____ or revoked by undersigned.

This release covers records that were created, or existing, on or before the date this authorization is signed, and records created between the date this authorization is signed and the date this authorization expires or is terminated. By signing this authorization, I am confirming that it accurately reflects my wishes.

Print Name:_____ Date:_____

Member Signature/Legal Decision Maker:_____ Date:_____

Signature is that of the: ☐ Member ☐ Legal Decision Maker