UPLANDS COUNSELING ASSOCIATES, INC (UCA)

1118 Professional Drive, Dodgeville, WI 53533 PH: 608-935-2838 FAX: 608-935-9227
6602 Grand Teton Plaza Suite 100, Madison WI 53719 PH: 608-828-3636 FAX: 608-828-3637

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Client Information (please print):

Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____Telephone: _____

I hereby authorize and request: **Uplands Counseling Associates, Inc (UCA)**

☐ To Release PHI To: ☐ To Obtain PHI From:

Person/Organization: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Protected Health Information (PHI) Authorized for Release:

☐ Initial Assessment (including Diagnosis/Prognosis/Psychosocial History/Presenting Problem/Symptoms/Medical)

☐ Progress Notes ☐ Treatment Plan ☐ Termination/Transfer of Care Note ☐ Consultation Notes

☐ Psychological Tests/Evaluations/Screening Tools/Reports

☐ Medication Management (includes H & P/Progress Note/Prescribed Medications & Dosages)

☐Hospital Records ☐ Admission/Discharge Summaries ☐ After Care Plan ☐Medical Visit Summaries ☐ Lab Results

☐School functioning ☐ Individual Educational Plan (IEP) ☐ Testing Results

☐Other (including Verbal/Written Exchange Regarding Treatment): _____

Purpose of the Release of PHI: ☐ To Coordinate Care ☐ Other: _____

This authorization will remain in effect until the above disclosure(s) has been completed. To specify that this authorization will remain in effect for an additional time period, please check one of the boxes below. **NOTE**: If you specify an additional time period, this authorization will apply to Protected Health Information (PHI) that was generated during the additional time period.

☐ ***in effect until _____ (mm/dd/yy***) ☐ ***24 months from date signed*** ☐ ***when treatment ends***

PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my Protected Health Information (PHI). This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness and/or HIV test results, with the following exception(s): _____

Signature of Client: _____ Date: _____

Signature of Other Person legally authorized to consent to the release of PHI:

Signature: _____ Date: _____

Client is a: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased **Legal Authority of Other Person:** ☐ Health Care Agent

☐ Parent ☐ Legal Guardian ☐Spouse of Deceased ☐Personal Representative of Deceased ☐ Other:_____

Witness: _____ Date: _____

ADDITIONAL INFORMATION REGARDING THE SHARING OF CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

Uplands Counseling Associates, Inc. (UCA) honors a client's right to the confidentiality of their Protected Health Information (PHI) as provided under federal and state law. Please read the following guidelines before signing this authorization to release PHI.

No Obligation to Sign. You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, Uplands Counseling Associates, Inc. (UCA) clinicians may not refuse to provide you behavioral health treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization to release PHI, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your PHI that the person (s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be in writing and sent to our Dodgeville or Madison location:

- Uplands Counseling Associates, 1118 Professional Drive, Dodgeville, WI 53533
- Uplands Counseling Associates, 6602 Grand Teton Plaza, Suite 100, Madison, WI 53719

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your PHI are not health care providers or other people who are subject to federal health privacy laws, the PHI information they receive may lose its protection under federal health privacy laws and those people may be permitted to re-release your PHI information without your prior permission.

Right to Inspect. You have the right to inspect or copy the PHI information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the clinician at Uplands Counseling Associates, Inc. (UCA) from whom you received care.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your PHI. If you are under the age of 18, your parent or legal guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact your clinician at Uplands Counseling Associates, Inc. (UCA).