VISIONARY PSYCHIATRY AUTHORIZATION
FOR USE & DISCLOSURE OF HEALTH/ CONFIDENTIAL RECORDS

Patient Information: (please print) Today's Date: _____

Name: _____ Date of Birth: _____

Address: (street, city, state & zip) _____

Phone: _____ Email: _____

Patient gives permission to: (please print) ☐ **Disclose to** ☐ **Obtain From** ☐ **Information Exchange with**

Name of Individual/ Agency/ Organization/ Other: _____

Address: (include street, city, state and zip code) _____

Phone: _____ Fax: _____

Date records are needed by: _____
Please note it can take up to 30 days for records to be sent out

Information to be released/ disclosed: (mark x= yes, blank= no)
Note: Information to be released may be in written, verbal, voicemail, fax or electronic form

_____ All Records **OR**

_____ Intake/Initial Assessment
_____ Medications
_____ Progress Notes
_____ Treatment Plans
_____ Discharge Summary
_____ Insurance/Billing
_____ Oral/UDS Testing
_____ Diagnosis Codes
_____ Appointments/Attendance
_____ Laboratory Reports

In compliance with state statutes, which require special permission to release otherwise privileged information, please release records pertaining to: (check all that apply)

☐ Alcohol or Drug Abuse/Treatment (AODA)
☐ Developmental Disabilities
☐ HIV/AIDS
☐ Mental/Behavioral Health Conditions
☐ Sexually Transmitted Diseases

Dates of Information to be disclosed: FROM: _____ **TO:** _____

Purpose of disclosure: (check all that apply)

☐ **Collaboration of Care**
☐ **Transfer of Care**
☐ **Legal Matters**
☐ **Personal**
☐ **Disability**
☐ **Insurance/Eligibility/ Benefits**
☐ **Other.**

This authorization lasts for **one year** after the date you sign it unless you enter a different date or expiration date here: _____

Visionary Psychiatry
Main Office: 535 SE Washington Street Hillsboro, Oregon 97123
Phone: 503-755-6703; Fax: 503-755-6704
Website: https://www.visionarypsych.com/

Additional Information Regarding
RELEASE OF PATIENT MEDICAL RECORDS

Visionary Psychiatry recognizes the patient's right to confidentiality of medical records as set forth in HIPAA and the Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

1) The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and upon paying any applicable fees, may obtain a copy to be disclosed pursuant to this consent form. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director, or designee, during the patient's treatment under certain exceptional circumstances. Federal law (HIPAA) grants extra privacy protection to psychotherapy notes and their release may be restricted, Section 51.30, Wis, Stats., DHS 92.03-92.06 Wis. Adm. Code.

2) The patient must specify the date, event, or condition upon which this release will expire. If not indicated, this authorization will automatically expire one (1) year from the date of signature. This release may be revoked by a patient in writing except to the extent that action has already been taken pursuant to the authorization. To revoke this authorization, the patient must send written notice of revocation to Visionary Psychiatry, and to any other person or organization that has been authorized to release information pursuant to the authorization. Written revocations for Visionary Psychiatry should be sent to Visionary Psychiatry, 535 SE Washington Street Hillsboro, Oregon 97123

3) Generally, all patients 18 years of age or older must sign for release of their own medical records. Read the following to determine exceptions for patients older or younger than 18 years.

- All patients 18 years of age and over must sign for release of their own medication records unless the following conditions apply: 1) The patient is incompetent, 2) the patient is incapacitated and cannot sign the form, or 3) the patient is deceased.
- Patients 14 years of age or older may sign for release of medical records involving mental health or alcohol and drug treatment, as may the parent or guardian. Whenever possible, it is recommended that both the minor patient (14 years of age or older) and the parent or guardian authorize release of the records. When a patient is incapacitated, a person appointed as guardian/custodian or temporary guardian may sign. If the patient has given written authorization to another person to release information, the designated person can sign provided that written proof (such as a notarized power of attorney document) is made available.
- Generally, family members of living adult patients do not otherwise have authority to sign for the release of records. When the patient is deceased, the surviving spouse or personal representative of the patient may sign authorizations releasing records. When there is no surviving spouse, immediate family may consent. For this purpose, immediate family is limited to adult children, parents, grandparents, adult siblings of the deceased patient, and their spouses.
- All persons other than the patient and have available proof of legal authority to release the records. The above summary does not address all of the complex exceptions which permit others to authorize release.

The Mental Health Records disclosed to you by this authorization are protected from re-disclosure by Wis. Admin. Code DHS 92.03(s)(d) This Wisconsin Administrative code prohibits you from making any further disclosures of this information unless the disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical records or other information is not sufficient for this purpose. If patient refuses to sign the authorization form required by HIPAA see 45 CFR Part 164.508 (c)(2)(ii) then records will not be shared. Right to have copies of the disclosed information required by WI State Statutes 51.30, DHS 92.03(3)(d)

This request may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Visionary Psychiatry Notice of Private Practice describes how to cancel (revoke) this authorization

A photocopy/fax/image of this authorization will be treated in the same way as the original

Visionary Psychiatry records may include records which it received from other organizations. If these records have been used by Visionary Psychiatry and filed in the Visionary Psychiatry records about you, these records may be released with your Visionary Psychiatry records. Visionary Psychiatry cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

By signing this authorization, you release Visionary Psychiatry from any and all liability resulting from disclosure by the recipient.

Your signature indicates that you have **read** and **understand t**his form, and authorize release of your information as described above.

_____ _____

Printed Name of Patient **Signature of Patient**

_____ _____

Printed Name of Legal Guardian (if patient under 18) **Signature of Legal Guardian (if patient under 18)**

If signed by a person other than the patient then circle any and all that apply:

Patient is:	Minor	Incompetent	Unable to sign due to disability	Deceased
Legal Authority:	Parent of Minor	Legal Guardian*	Power of Attorney*	Other*

*if you circle any of the above, you must have proof of legal authority attached to this authorization or on file in patient's chart before any records will be released. (i.e. Guardianship papers, Power of Attorney documents, etc)

For Office Staff Only:

Visionary Psychiatry Staff Initials: _____

Date Records Sent: _____

Records Sent Via: _____