North Central Health Care
Person centered. Outcome focused.

Client ID# _____

NAME _____ DOB _____ SSN# _____
(also list maiden name/other names used)

I hereby request and authorize:

NORTH CENTRAL HEALTH CARE FACILITIES

☐ **Wausau Campus**
1100 Lakeview Drive
Wausau, Wisconsin 54403
Phone: 715.848.4600
Fax: 715.842.2017

☐ **Merrill/Tomahawk Center**
607 N. Sales Street, Ste 309
Merrill, Wisconsin 54452
Phone: 715.536.9482
Fax: 715.539.2972

☐ **Mount View Care Center**
2400 Marshall Street
Wausau, Wisconsin 54403
Phone: 715.848.4300
Fax: 715.843.5733

☐ **Antigo Center**
1225 Langlade Road
Antigo, Wisconsin 54409
Phone: 715.627.6694
Fax: 715.627.6645

To: ☐ Disclose to ☐ Receive from ☐ Exchange with

Name: _____

Address: _____

City/State/Zip: _____

The following specific information from my records for dates of treatment: _____

For types of treatment:
☐ Mental Health/Psychotherapy ☐ Alcohol/Drug Therapy ☐ DD Services
☐ Crisis Intervention ☐ Nursing Home Record ☐ Aquatic Rehabilitation Therapy ☐ Medical Record
☐ Birth-to-Three ☐ Outpatient Rehab Therapy ☐ Other, specify: _____

The purpose of such disclosure is: (check all that apply)
☐ Continuing Health Care Needs ☐ Personal ☐ Transfer of Care ☐ Financial Assistance
☐ Care Coordination/Case Management ☐ Legal ☐ Disability ☐ Billing/Payment of Claims
☐ Other, specify _____

Information to be Disclosed: (check all that apply)
☐ Verbal Information ☐ Psychiatric Evaluation ☐ Discharge Summary/Note ☐ MD Notes
☐ Assessment Summary ☐ Psychological Evaluation ☐ Physical Exam ☐ Letters/Correspondence
☐ Treatment Plan ☐ Aftercare Plan ☐ Radiology/Lab Reports ☐ Questionnaires
☐ Progress Notes ☐ Other ("all records" not acceptable), specify: _____

I understand that I have a right to inspect and receive a copy of the materials to be disclosed as required under ss.DHS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I understand that this release allows for the exchange of HIV/Aids Testing, treatment and evaluations. I may revoke this authorization in writing at any time except to the extent that information already release pursuant to this consent cannot be recalled. [45 CFR 164.508(c)(2)(i)]. Authorizations of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (42 CFR Part 2.35). I understand that information used/disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. I further understand that I am entitled to a copy of this signed consent at any time.

This authorization is effective for up to one (1) year from the date of signing, or as specified: _____

Patient/Client/Resident Signature: _____ Date: _____

Parent/Guardian/Other Signature, specify: _____ Date: _____

Staff Signature: _____ Date: _____

Staff Department: _____ Staff ID#: _____

(Fax/Copy as effective as the original)

AUTHORIZATION OF DISCLOSURE / RELEASE OF INFORMATION