Aurora Health Care• *Milwaukee, Wisconsin*

MRN: _____

1) **AUTHORIZES:**
- ☐ Aurora Psychiatric Hospital
- ☐ Aurora Behavioral Health Center *(site):* _____
- ☐ Aurora Sheboygan Memorial Medical Center
- ☐ Aurora Health Care Metro, Inc.

Patient Name: _____

Date of Birth: _____

2) Name _____

Address _____ City _____ State _____ Zip _____

_____ (_____)_____ _____

Date of Birth | Daytime Phone | Previous Name

3) **NAME & RELATIONSHIP OF WHO MAY BE CONTACTED** (i.e., Insurance Company/Review Agency, Primary Care Physician, School, Employer, Therapist, Psychiatrist, Pharmacy, Family/Significant Other):

To Disclose to: ☐ Self

☐ Name/Facility _____ Relationship _____

Address _____ City _____ State _____ Zip _____

☐ Will pick-up ☐ Fax to: _____

Recipient (Contact) Phone Number: (_____)_____

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)**

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year)

6) **INFORMATION TO BE DISCLOSED:** ☐ **Verbal** ☐ **Written**

- ☐ Alcohol & Other Drug Abuse (AODA) Assessment
- ☐ Discharge Instructions
- ☐ Discharge Summary
- ☐ Diagnostic Tests: _____
- ☐ History & Physical
- ☐ HIV Test Results
- ☐ Identity and Presence in Treatment
- ☐ Lab Results
- ☐ Legal Status/Court Records
- ☐ Medications/Medication Profile
- ☐ Mental Health Assessment
- ☐ Progress Notes/Updates
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan
- ☐ Billing Records related to (specify): _____
- ☐ Other (specify): _____

7) **EXPIRATION:** This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

8) **PURPOSE** (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility / Benefits ☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment ☐ Other: _____

9) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim / policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and / or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10) **SIGNATURE OF PATIENT:** _____ **DATE:** _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE:** _____

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

RELEASED BY: _____ **DATE RELEASED:** _____