

**BridgePoint Health LLC**

**PO Box 387, Sheboygan, WI 53082-0387 920-458-5557(Phone) 920-458-2692(Fax)**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**1. Patient Information**

Name- Last, First, MI		
Street Address		
City	State	Zip Code
Medical Record Number	Birthdate	Phone No.

**2. Information to be Disclosed (Please check only one box)**

- Complete copy of official mental health record
- Records from \_\_\_\_\_ to \_\_\_\_\_
- Verbal exchange
- Other (please explain): \_\_\_\_\_

**3. Disclosed By:**

**4. Disclosed To:**

Name—(Facility, Physician...)			Name—(Insurance Co, Lawyer, Physician, Patient...)		
Address			Address		
City	State	Zip Code	City	State	Zip Code

**5. Purpose or need for disclosure (Please check all applicable categories)**

- further medical care
- application for insurance
- disability determination
- payment of insurance claim
- legal investigation
- other \_\_\_\_\_
- patient use
- transfer of care

6. This authorization will remain in effect until the above disclosures(s) have been completed (for a period of one year) unless you specify that this authorization will be effective for an additional time period. (To specify an additional time period, please check the box below. Please note that if you specify an additional time period, this authorization will apply to the services you receive during that additional time period.)

- Other specific expiration date: \_\_\_\_\_ (mm/dd/yy)

**\*\*\*PLEASE SEE REVERSE 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 medical information. In understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, and alcohol or drug treatment, with the following exception(s): \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

If signed by person other than patient, state relationship and authority to do so.

Relationship: \_\_\_\_\_

- Patient is:  Minor  Incompetent/Incapacitated  Deceased

Legal Authority:  Legal Guardian  Parent of Minor  Spouse of Deceased

Personal Representative of Deceased  Other \_\_\_\_\_

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**ADDITIONAL INFORMATION REGARDING DISCLOSURE  
OF PATIENT MEDICAL INFORMATION**

BridgePoint Health LLC honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

**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, BridgePoint Health Providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

**Revocation.** You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(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 made in writing and addressed to: Director of Business Operations, PO Box 387, Sheboygan, Wisconsin 53082-0387.

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

**Right to Inspect.** You have the right to inspect or copy the medical 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 medical records department.

**Copying Fees.** If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for all other purposes.

**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 disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. If you are 14 years of age or older, you and your parent or guardian must sign this form. If you are 12 years of age or older and requesting AODA records, you and your parent or guardian must sign this form. For more information regarding who is authorized to sign this form, contact BridgePoint Health, 3425 Superior Avenue, Sheboygan, WI 53081, (920) 458-5557.

PHOTOCOPY VALID AS ORIGINAL