**The REDI Clinic of Wauwatosa, SC**
2500 N. Mayfair Rd, Ste 600, Wauwatosa, WI 53226
Phone: 414-727-4455 Fax: 414-727-4690

# AUTHORIZATION FOR USE / DISCLOSURE OF PATIENT HEALTH INFORMATION

_____ /_____ _____
(Patient Name) (Previous Name) (Date of Birth)

I authorize The REDI Clinic ☐ to release my medical record; ☐ to obtain my medical record; ☐ to mutually share my medical record

**WHO MAY BE CONTACTED:**

_____ _____
(Name of Person/Entity) (Relationship)

_____
(Address) (City) (State) (Zip)

_____ _____
(Phone) (Fax)

**WHAT MAY BE DISCLOSED:** ☐ **VERBAL COMMUNICATION** ☐ **WRITTEN RECORDS**

☐ Therapy Records ☐ Discharge Summary ☐ Treatment Plans

☐ Psychiatry Records ☐ Medication List ☐ Other (specify): _____

☐ Nutrition Records ☐ Lab Results ☐ All Records for following date range: _____

**PURPOSE OF DISCLOSURE:**

☐ Coordination of Care ☐ Legal ☐ School/Employment ☐ Personal Purpose

**EXPIRATION:**

This authorization is valid until the following date / event: _____
NOTE: If this item is left blank, the authorization will expire in one (1) year from the date of signature.

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 REDI Clinic 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 understand 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. A photocopy/facsimile copy is as valid as the original document.

**SIGNATURE:**

☐ I am the patient
☐ I am the parent of the above named minor child, and I represent that I have not been denied access to my child by a court of law and / or denied periods of physical placement with my child
☐ I am the legal guardian, next-of-kin, executor, or Power of Attorney for the above named patient (documentation required)

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____