Journey MENTAL HEALTH CENTER
www.journeymhc.org
Formerly known as the
Mental Health Center of Dane County Inc.

CONSENT FOR RELEASE OF INFORMATION

625 W. Washington Avenue
Madison, WI 53703
Phone: (608) 280-2700
Fax: (608) 280-2707

(NOTE: Information is shared between JMHC programs according to JMHC confidentiality policies.)

1 **I hereby authorize:** Journey Mental Health Center, Inc.
625 W. Washington Avenue, Madison, WI 53703

2 ☐ **To release information to:** ☐ **To obtain information from:**
(Check one box or both. By checking both, you are authorizing an exchange of information between the agencies/individuals listed).

Agency and/or individual: _____

Street/City/State/Zip Code: _____

3 **From the records of:**
Consumer Name: _____ Date of Birth: _____

Other names used: _____

4 **Purpose of need for disclosure: (check all that apply)**
☐ Service Coordination ☐ Mental Health and/or Substance Abuse Assessment/Treatment
☐ Crisis Management ☐ Other (specify): _____

5 a) **Types of information to be disclosed: (check all that apply)**
☐ Mental Health ☐ Alcohol & Other Drug ☐ Medical ☐ HIV/AIDS
☐ Educational ☐ Developmental Disabilities ☐ Human Services

☐ Other (specify): _____

b) **Specific information to be disclosed (check all that apply)**
☐ Intake Summary ☐ Progress Notes ☐ Treatment Plans ☐ Clinical Impressions
☐ Assessments + Diagnoses ☐ Medication Notes ☐ Summary Reports ☐ Consultation
☐ Lab Results ☐ Discharge Summary

☐ Other (specify): _____

6 **I understand that:**
(a) My records are protected under State and Federal regulations governing confidentiality.
- Mental Health - Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
- Alcohol & Other Drug Abuse - 42 CFR, Part 2; Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, pts 160 & 164

(b) I will receive a copy of this form and have the right to inspect/receive a copy of materials to be disclosed.
(c) If the person(s) and/or organization(s) authorized by this form to receive my health information are not health care providers or other people who are subject to federal health privacy laws, the health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my health information without my prior permission.
(d) I am not required to sign this form and may refuse to do so. Except as permitted under applicable law, JMHC many not deny me services because I refuse to sign.
(e) I may revoke this consent at any time by giving written notice to my JMHC service provider(s) or to the JMHC Records Department, except to the extent that information has already been disclosed based on this release.

7 **This consent expires in one year unless earlier date is indicated here:** _____

_____ _____
Consumer Signature Date

_____ _____
Signature of Other Person Authorized to Consent for Consumer (where applicable) Date

_____
Relationship to Consumer

_____ _____
Witness Signature (if Consumer can not sign his/her name) Date

A PHOTOCOPY, FAX OR ELECTRONIC IMAGE OF THIS CONSENT IS AS VALID AS THE ORIGINAL (Rev.11/07/2011)