Psychology Research & Training Clinic

W.J. Brogden Building, Room 351
Department of Psychology
1202 West Johnson Street
Madison, WI 53706
Phone: 608.262.5925 Fax: 608.262.5796

THE UNIVERSITY of WISCONSIN MADISON

PRTC Individual Consent for Release of Information

1. I hereby authorize the Psychology Research and Training Clinic
Room 351, W.J. Brogden Psychology Building
1202 West Johnson Street, Madison, WI 53706
(608) 262-5925

2. [ ] Release information to:
[ ] Obtain information from:
[ ] Exchange information with:
[ ] Phone contact only:

Name: _____
Address: _____
_____
Phone: _____

3. Information regarding:

_____
(Clearly print first & last names) (Date of birth)

_____
(Indicate previous name(s) used, if any)

4. Purpose or need for disclosure: (check those that apply)

[ ] Evaluation/assessment
[ ] Further psychological care
[ ] Other (specify)_____
[ ] Treatment coordination
[ ] Billing of 3rd Party _____

5. Specific information to be disclosed:

[ ] Intake evaluation
[ ] Therapy notes
[ ] Psychological testing/evaluation
[ ] Psychiatric evaluation/consultation records
[ ] Other (specify)_____
[ ] Medical records
[ ] Inpatient hospitalization
[ ] AODA evaluation/treatment
[ ] School behavior and academic records

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care on my decision to sign this authorization.

MY RIGHT TO REVOKE THIS AUTHORIZATION. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact my therapist or the Psychology Research & Training Clinic. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

REDISCLOSURE OF MY HEALTH INFORMATION. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards regarding health care information, this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

I have the right to receive a copy of this form after I sign it. **This authorization is valid for 6 months from the date signed, or until _____, unless otherwise stated or revoked through written notice.**

6. Signature of client:_____ Date:_____

7. Signature of authorized person: _____ Date:_____

8. Witness: _____ Date:_____

If signed by person other than client, please check one: [ ] legal guardian [ ] parent of minor [ ] next of kin [ ] power of attorney