1. Patient Name:_____

Maiden/Former Name:_____

Date of Birth:_____

Address:_____

_____

Phone Number:_____

Clinic Number (if known):_____

La Crosse, WI 54601
1900 South Avenue, AVS-001, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 53199 or (608) 775-3199
FAX AUTHORIZATION TO: (608) 775-4706 or (608) 775-0548
FAX MEDICAL RECORDS TO: (608) 775-3488
EMAIL: medicalrecords@gundersenhealth.org
HOURS: Monday - Friday, 8:00 am – 5:00 pm

I hereby Authorize: Written Communication Between 2 & 3? ✖ Yes ☐ No
Verbal Communication Between 2 & 3? ✖ Yes ☐ No

2. **Information Disclosed From:**

Behavioral Health Mail Stop: H04-004
(Name of Person or Organization(Gundersen Health System)

1900 South Avenue
Street Address

La Crosse WI 54601
City State Zip

(608) 775-2287 (608) 775-4732
Phone Number Fax Number

3. **Information Disclosed To:**

Chileda Institute
(Name of Person or Organization(Gundersen Health System)

1825 Victory St
Street Address

La Crosse WI 54601
City State Zip

608-782-6480 608-782-6481
Phone Number Fax Number

4. **Please CHECK ONLY ONE BOX:**

☐ Mail Records
☐ Fax Records (provide fax number above)
☐ Email: _____ ******FOR PATIENT REQUESTS ONLY******
(Please Print Email Address)
☐ Will Pick Up Records **(La Crosse Campus ONLY)**
☐ No records needed at this time. File in patient's medical record for future use.

5. **Format for Records:** ☐Paper **OR** ☐CD/DVD (requires PDF viewer). Please check only one box.
Please note, if a format is not selected, records will be in paper format

6. **Type of Information to Be Disclosed:** ☐Medical Records ✖Behavioral Health (#7 required)☐Both (#7 required)
2 year history unless specified: August 1, 2008 to _____,

_____

_____

7. **State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed:**

✖ Mental Health ✖ Alcohol/Drug Abuse ✖ Developmental Disability ☐ HIV Testing

8. **Purpose or need for disclosure (check one):** ✖Further Medical Care ☐Insurance Claim ☐Personal
☐Legal Investigation ☐Insurance Application ☐Disability Determination ☐Other:_____

9. **Expiration Date:** This authorization is valid for 1 year from date of signature or until _____ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

1. Patient Name:_____

Maiden/Former Name:_____

Date of Birth:_____

Address:_____

_____

Phone Number:_____

Clinic Number (if known):_____

GUNDERSEN HEALTH SYSTEM®
La Crosse, WI 54601
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Your Rights With Respect To This Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not limited to: Mental Health – Sec 51.30, Wis. Stats; & HFS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, HFS 92, Wis. Admin. Code; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties. Prohibition on redisclosure. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Right to Receive a Copy of this Authorization: I have a right to receive a copy of this form after I sign it. Right to Refuse to Sign This Authorization: I am under no legal obligation to sign this form, however, under certain circumstances permitted under applicable law; refusal to sign may result in denial of services. Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential. Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

In accordance with the conditions listed on the first page of this form and above, I authorize the use and disclosure of my medical information. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. This authorization may be revoked in writing at any time by submitting a request to Release of Information at the address above. This form must be legible and the first page must be completed in full (numbers 1– 9) in order to be valid.
Copies of records may be obtained with reasonable notice and payment of copying costs. Fees may apply.

Signature of Patient:_____**Date**:_____

Signature of Parent/Guardian:_____**Date**:_____
(If not signed by patient, identify relationship to patient. If Legal Guardian or other, provide a copy of the court order establishing the person's authority)

Legal Authority:

- ☐ Parent of Minor ☐Legal Guardian ☐Spouse of Deceased
- ☐ Personal Representative/Domestic Partner of Deceased
- ☐ Health Care Agent: _____
- ☐ Other:_____

Patient Name: _____

Clinic Number: _____

GUNDERSEN HEALTH SYSTEM®

DEPARTMENT OF BEHAVIORAL HEALTH
CONSENT FOR TREATMENT

I voluntarily consent to treatment through Gundersen Behavioral Health.

I have received and had explained to me:

- Description of Services
- My Rights and Responsibilities
- The Grievance Procedure
- The Cost of Services
- Emergency Procedures

I understand that Gundersen Behavioral Health uses a multi-disciplinary care team that includes psychiatrists, psychologists, nurse practitioners and other mental health and substance abuse care providers.

I will participate in the development of my treatment plan and care. As part of my treatment plan development, I will discuss the benefits of treatment, time frame of treatment, modality of treatment, possible side effects or risks, alternative modes or services, and consequences of not receiving treatment. I understand that the signing of my treatment plan indicates my consent to treatment as described by the plan and my provider.

I understand that I will need to attend regularly scheduled appointments as defined by my treatment plan. Failure to do so may result in discharge from care. In addition, if you fail to show for an appointment and don't cancel, you will be assessed a fee.

I understand that I can withdraw my consent for treatment at any time in writing. By signing below, this consent will remain in effect for 15 months from the date of my (patient/parent/legal guardian) signature.

_____ _____
Patient Signature (required if 12 or over) Date

_____ _____
Parent/Legal Guardian Date
(If patient is unable to sign or is under age of 18, please complete.)

_____ _____
Staff Member Date

_____ _____
Care Provider Date

Check if Applicable:
☐ **I understand that my provider is not currently licensed in the State of Wisconsin and is practicing under the supervision of another licensed provider according to any/all applicable laws and professional standards.**

Patient Name:_____

Medical Record Number:_____

Date of Birth: _____

Contact Serial Number:_____

HAR#:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Gundersen Clinic, Ltd. and Gundersen Lutheran Medical Center, Inc. (collectively "Gundersen Health System") must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member or to leave a message regarding your health care on you telephone answering machine. This is especially helpful if you are on medications that require frequent testing and adjustment, in case there is an urgent need to contact you if we need to reschedule an appointment, test or procedure and you are not available when we call or if there is someone who assists with your finances.

The type of information disclosed: medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, and alcohol and drug abuse, unless otherwise specified below. This form **DOES NOT** authorize the disclosure of any of your written health information.

Verbal Communication Regarding My Treatment Can Be Shared With (please print):

(Name and Relationship	(Phone Number)	(Type of Information)
Chileda Institute Professional Staff	608-782-6480	☑ All ☐ Only Behavioral Health ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Only Behavioral Health ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Only Behavioral Health ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Only Behavioral Health ☐ Limited to: _____

Please indicate below where we may contact you and leave a message regarding your Medical, Behavioral Health and/or Financial information, if appropriate:

Home: _____ Work: _____ Cell: _____

You may refuse to sign this authorization with the understanding that this may result in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization will expire in two years from the date signed.

_____ _____

Signature of Patient Date

_____

(If signed by authorized person, state relationship and authority to do so.)

Contact Information Concerning Patient or Legal Guardian:
(Applicable only if patient is a minor or has a Legal Guardian. PLEASE PRINT)

_____	_____	_____
Name	Relationship to Patient	Contact Phone Number
_____	_____	_____
Name	Relationship to Patient	Contact Phone Number