MCHC
MUSLIM COMMUNITY & HEALTH CENTER

Release of Information
803 West Layton Avenue
Milwaukee, WI 53221

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____, _____, _____
PATIENT NAME *DATE OF BIRTH* *PHONE NUMBER*

AUTHORIZES DISCLOSURE FROM:
MUSLIM COMMUNITY & HEALTH CENTER
803 West Layton Avenue
Milwaukee, WI 53221

TO RELEASE MEDICAL INFORMATION
_____
Name of Health Provider/Organization/Individual
_____
Street Address
_____
City State Zip

☐ **Check here if authorization is reciprocal (both the disclosing party and the recipient can mutually exchange information below).**

Purpose: (Check all that apply)
- ☐ To report attendance at EAP assessment
- ☐ Treatment planning
- ☐ Further follow-up care
- ☐ Other (specify) Information to be disclosed: _____

Information to be disclosed: ☐ Verbal ☐Written
- ☐ Report attendance at EAP assessment & agreement to follow through
- ☐ Compliance with treatment recommendations and appointments
- ☐ Failure to comply with EAP recommendations
- ☐ Reports of progress and treatment
- ☐ Other (specify) _____

Dates of information to be disclosed: From_____ To_____

Expiration Date: This Release is good until the following date(s)/events: _____ If no date or event is specified, this Release will expire one (1) year from the date signed.

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 am also aware that I may revoke this Authorization by notifying the Aurora EAP 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 realize 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.

I have had an opportunity to review and understand the content of this Release. By signing this Release, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Client *Date*

If signed by a LEGAL REPRESENTATIVE, complete the following:
1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐parent* ☐ legal guardian ☐ next of kin/executor of deceased☐activated POA for Health Care * By signing above, I hereby declare that I have not been denied physical placement of this child