Instructions for Christian Family Solutions Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions aboutthe release of your health information or this form, please contact the Christian Family Solutions records department at 800-438-1772.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix afteryour last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. All these items are used to identify your health information and to make certain that only your information is sent. If you are the legal guardian of a minor, please complete the form with their identifying information.

2 In this section, state who is sending your health information**. Please be as specific as possible and include location and/or program(s) if applicable.** If you want to limit what is sent, you can name a specific facility, or name a specific professional, or service provided, for example medication management.

3 Indicate where you would like the requested health information to be exchanged. It is best to provide a complete mailing address as not everyone will receive faxed health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.** CFS will prepare your records in a timely manner to meet state and federal guidelines. **Please note it may take up to 30 days to complete your request.**

4 Indicate what health information you want sent. Please indicate specific date(s) or year(s) to include on the line provided.
If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

5 **Important:** There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcoholor drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, check the box and initial in this section.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

6 Health information includes both written and oral information. If you do not want to give permission for persons in Section 3 to talk with persons at Christian Family Solutions about your health information, you need to indicate that in this section. **Only written information will be shared if you initial this section.**

7 Please indicate the reason for releasing the health information.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the program," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

A fee may be charged for the release of the health information.

Fax completed form to 262-345-5562.

W175 N11120 Stonewood Drive | Germantown, WI 53022-6511
Fax: 262-345-5562 | 800-438-1772 | ChristianFamilySolutions.org

CHRISTIAN FAMILY SOLUTIONS
Counseling Care & Services

Christian Family Solutions Consent Form to Release Health Information

CHRISTIAN FAMILY SOLUTIONS
Counseling Care & Services

1 Patient information

First Name_____ Middle Name_____ Last Name_____

Patient date of birth (MM/DD/YYYY)_____ Previous name(s) _____

Home address _____

City_____ State_____ Zip code_____

Daytime phone_____ E-mail address _____

2 I am authorizing health information be exchanged from:

Organization's Name _____

And/or persons_____

Mailing Address _____

City _____ State_____ Zip _____

Phone (optional) _____ Email or Fax _____

Information needed by (MM/DD/YYYY) _____

3 I am requesting that health information be exchanged to:

Organization's Name _____

And/or persons_____

Mailing Address _____

City_____ State_____ Zip _____

Phone (optional) _____ Email or Fax _____

Information needed by (MM/DD/YYYY) _____

4 Information to be exchanged:

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment: FROM_____ TO_____

Please include:

☐ All health information *(see description in instructions for what is included)*

☐ Abstract=Discharge Summary, Psychiatric Evaluation, History & Consults, and Medications

OR to only release specific portions of your health information, indicate the categories to be released:

☐ Psychiatric Evaluation
☐ Medication List
☐ Education Planning
☐ Safety Plan
☐ Scheduled Appointments
☐ Mental health
☐ Discharge summary
☐ Progress notes
☐ Care plan
☐ Date of service letter
☐ Treatment Plans
☐ Clinical Summary
☐ Photographs, video, digital or other images
☐ Billing records
☐ Lab results

☐ Other information or instructions _____

Christian Family Solutions Consent Form to Release Health Information

Patient's Name_____

5 **The following information requires special consent by law.** Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program (see definition in instructions)

6 **Health information includes written and oral information.** By indicating any of the categories in Section 4, you are giving permission for written information to be released **AND** for your provider at Christian Family Solutions to talk to a person in Section 3 about your health information.

If you do not want to give your permission for your provider to talk to a person in Section 3 about your health information, indicate that here (initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Insurance application
- ☐ Legal
- ☐ Scheduling or coordinating appointments
- ☐ Coordinating transportation
- ☐ Coordinating of care with PCP/Psychiatrist

☐ Other (please explain) _____

8 I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in Section 3.

- I may stop this consent at any time by writing Christian Family Solutions at records@wlcfs.org
- If Christian Family Solutions has already released health information based on my consent, my request to stop will not work for that health information.
- I understand that when the health information specified in Section 4 is sent to the third party named in Section 3, the information could be redisclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
- I understand that if the organization named in Sections 2 or 3 is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.
- If I choose not to sign this form and the organization named in Section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.
- I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Regulations, but that all recipients of information related to alcohol and drug abuse patient records are informed of the prohibition against disclosure as required by the Confidentiality Regulations found at 42 C.F.R. Part 2 which prohibits unauthorized disclosure of these records.
- I understand that I have a right to a copy of this authorization and that I have the right to inspect or receive a copy of the material to be disclosed.
- I understand that a photocopy/facsimile copy of this document is as valid as the original form.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date____ ____ _____ (MM/DD/YYYY) Or specific event_____

9 **Patient's signature** _____Date_____ ____ _____ (MM/DD/YYYY)

OR legally authorized representative's signature_____Date_____ ____ _____ (MM/DD/YYYY)

Legal Authority: ☐ Parent ☐ Legal Guardian ☐ Activated Power of Attorney for Healthcare

If you are signing as a parent of a minor patient, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health.

☐ guardianship documents enclosed ☐ guardianship documents on file

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