# LEES PSYCHOLOGICAL SERVICES

**Release of Information**
**Authorization for Use/Disclosure of Protected Health Information**

Use this form to receive a copy of your health care information that Lees Psychological Services maintains regarding your treatment. **LPS only maintains paper records and can only provide copies in the same format (NOTE: Each progress note is double-sided or 2 pages).**

Patient Name: _____ Date of Birth: _____

**Authorization of Use/Disclosure of Information:** I voluntarily consent to authorize the listed person(s), organization(s) and/or health care provider(s) to receive and use my treatment records and/or health information during the term of this Authorization to the recipients I have identified below.

**Disclosure:** I authorize Lees Psychological Services, Inc. or their designee, to release/disclose my treatment records and/or health care information.

**Recipient:** I authorize my treatment records and/or health care information to be released to the following recipient (an Authorization form must be filled out for each recipient if there is more than one):

Myself (the patient) Only – Please initial: _____

Name: _____

Address: _____

Date(s) of Treatment Requested: _____

**Purpose:** I authorize the release of my health information for the following specific purpose:

_____Continuity of Care (Transfer to a new therapist)
_____Legal
_____Personal Record
_____Other: _____

**Information to be Disclosed:** I authorize the release of the following health information (Check the applicable option):

_____All of my health/treatment information from the assessment or treatment that the provider rendered and has in her possession.
_____Only the following type of health information: _____
_____
_____

**Term:** I understand that this Authorization will remain in effect until the request is fulfilled.

**Right to Revoke:** I understand that signing this Authorization is voluntary. If I change my mind, I understand that I can revoke this Authorization by providing written notice to Lees Psychological Services via email at clinic@leespsych.net. The revocation will be effective immediately upon receipt of the written notice. However, the revocation will not have any effect on any action taken by Lees Psychological Services in reliance on this Authorization before a written notice of revocation is received.

**Non-Health Care Providers:** I understand that a person(s) or organization(s) or their affiliated organization(s) that is not a health care provider is not subject to federal privacy standards. As such, my health information disclosed to a non-health care provider(s) pursuant to this Authorization may no longer be protected by federal privacy standards if the recipient(s) is not bound by federal privacy standards. I understand that such person(s) or organization(s) may redisclose my health information without obtaining my authorization.

**Cost:** I understand that Lees Psychological Services charges for the release of records. Pursuant to Wis. Stat. §146.83 (3f) (c) 2., the dollar amounts a health care provider may charge ***per page, plus postage,*** for providing copies of a patient's health care records are as follows:

First 25 pages: $1.08 per page
Pages 26-50: $0.80 per page
Pages 51-100: $0.53 per page
Pages 101 and above: $0.31 per page
Plus Postage

**Questions:** I may contact Lees Psychological Services for answers to my questions about the privacy of my health information at 414-774-6878 or clinic@leespsych.net.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(Required)

If the patient is unable to sign this Authorization, please complete the following:

Printed Name of Guardian/Representative: _____

Legal Relationship: _____

Guardian/Rep Signature: _____ Date: _____
Witness Signature: _____ Date: _____
(Required)

**IMPORTANT:**
****Email a copy of the Patient's and/or Guardian's Driver's License with this Authorization****