

# Westmont Law Offices, S.C.

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

### 1. Patient/Client Information

Name (Last, First, MI) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State and Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

### 2. Information to be Disclosed.

- Complete copy of official medical record
- Comprehensive overview of entire chart (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray, EKG and lab reports)
- Records pertaining to the following date(s) or condition(s): \_\_\_\_\_
- Records of evaluation and/or treatment for physical and/or mental illness including past history, diagnosis, prognosis, medication, workshop evaluations, training reports, I.Q. scores, treatment plan, recommendations
- Employment records
- School records
- Current probation status and all probation records
- Other (describe): \_\_\_\_\_

### 3. Disclosed By:

Name (e.g Health Facility, Physician...) \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

### 4. Disclosed To:

**Westmont Law Offices, S.C.**  
**1837 Aberg Avenue**  
**Madison, WI 53704-4201**

5. The purpose or need for disclosure is for legal investigation and/or legal action.

6. This authorization will remain in effect until the above disclosures have been completed or until \_\_\_\_\_, whichever is later.

You are also authorized to discuss this case or give a written report to **Westmont Law Offices, S.C.** A photocopy of this authorization shall be considered as effective and valid as the original.

**\*\*PLEASE SEE OTHER SIDE FOR FURTHER INFORMATION\*\***

**In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical or other information.** I understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Patient is:       Minor                       Deceased                       Incompetent/Incapacitated  
                     Legal Guardian       Parent of Minor               Spouse of Deceased  
Relationship:  Health Care Agent       Personal Representative of Deceased  
                     Legal Authority               Other: \_\_\_\_\_

## **ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION**

Please read the following guidelines before signing this authorization.

**No Obligation to Sign.** You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, the person(s) and/or organization(s) listed on the reverse side of this form (the entity to whom this release is directed) may not refuse to provide you treatment or other health care services if you refuse to sign this form.

**Revocation.** You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical or other information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. Your revocation must be made in writing and addressed to: Westmont & Congo Law Offices, S.C., 1837 Aberg Avenue, Madison, WI 53704.

**Re-release.** Because Westmont & Congo Law Offices, S.C. are not health care providers and are not subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and they may be permitted to re-release your medical information without your prior permission.

**Right to Inspect.** You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the health care provider or facility where you have received care.

**Copying Fees.** If you are requesting disclosure or release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

**Signatures.** Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact Westmont & Congo Law Offices, S.C., 1837 Aberg Avenue, Madison, WI 53704 (608) 244-9494.