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 ___Legal Guardian ___Parent of Minor ___ Incompetent/Incapacitated ___ 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 Law Offices, S.C., 1837 Aberg Avenue, Madison, WI 53704.

Re-release. Because Westmont 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 Law Offices, S.C., 1837 Aberg Avenue, Madison, WI 53704 (608) 244-9494.