



Psychiatry

Follow these instructions carefully when completing the authorization form.

Please fill in the content of the form by printing neatly or typing.

The form must be completed in its entirety and both page of the form must be returned. Failure to do so can result in a delay to process this request to release your medical record information.

Follow these steps:

- Section 1: enter the patient name (maiden or former name if applicable), full address, date of birth, and phone number.
- Section 2: choose the information to be disclosed.
- Section 3: specifies the information is being disclosed by Wisconsin Psychiatric Institute and Clinic.
- Section 4: supply the complete name and mailing address of the individual or entity that is to receive the copy of your medical information.
- Section 5: check the box or boxes that best describe(s) the purpose of your request.
- Section 6: in the event you want this release to remain in effect for an additional time period you can provide a specific date of expiration. Otherwise the release will expire once the initial disclosure is made.
- Section 6: complete with signature and date, and disclosure of identity of signee if other than the patient.
- Return completed page 1 and page 2 (ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION) via fax to 608-203-4580 or mail to:

WISPIC – Health Info Mgmt.
8501 Excelsior Dr.
Madison, WI. 53717

Questions regarding this process can be directed to 608-263-6030, option 3.

Note: medical information will not be released if page 2 is not returned with page1.