CONSENT FOR TREATMENT – GENERAL

In consideration of treatment to be rendered to me by the Milwaukee County Behavioral Health Division Service System, Inpatient Services, Psychiatric Crisis Service, Outpatient Services, or contracted community services, I hereby consent to such care and treatment as may be deemed proper in the judgment of the clinical staff of the Milwaukee County Behavioral Health Division.

CONSENT FOR TREATMENT – PSYCHIATRIC CRISIS SERVICE

I, the undersigned, do hereby authorize and consent to any services of an emergency nature, including but not limited to psychiatric interview and other diagnostic procedures, laboratory procedures, medical, and other hospital services which are deemed necessary or advisable to by the attending physician(s) and rendered to me under the general or special instructions of said physician(s).

I acknowledge that the care which will be furnished to me in the Psychiatric Crisis Service Center in the Milwaukee County Behavioral Health Division will be limited solely to emergency treatment. I understand that I may be released before all of my medical or psychiatric problems are known or treated, and that it will be necessary for me to make arrangements for follow-up care. I do also hereby release the Milwaukee County Behavioral Health Division, all of its agents, employees and attending physician(s) from responsibility for anything but such emergency treatment.

RELEASE OF INFORMATION

I, further consent that the Milwaukee County Behavioral Health Division and contract agencies may disclose any medical record or billing data to any and all public or private health care insurers, reimbursement agencies, third party payers, and funding sources providing health care insurance of reimbursement to or on behalf of the patient, including but not limited to Medicare, Medicaid, Milwaukee County Department of Human Services, for the purpose of reimbursement, for all episodes of treatment during the next three years. In the event that my HMO/insurance determines that inpatient care should be provided at a facility of their choosing, I authorize Milwaukee County Behavioral Health Division to provide information to the receiving facility for the purpose of coordinating my continued care. I also authorize the Milwaukee County Behavioral Health Division to notify my primary care physician of my hospitalization when required by my insurance provider. I understand the specific type of information to be disclosed includes diagnosis, prognosis, and treatment for physical illness, and where applicable, mental disorders, alcohol or drug abuse, HIV test/results or AIDS, or any AIDS related diagnosis. This consent for release of information is subject to revocation at any time except to the extent that action has been taken in reliance thereon and, in any event, will expire when final payment for these services have been made, but in any case it is not to exceed three years. I authorize such disclosure with the further understanding that any written information disclosed under the conditions of this document will be accompanied when applicable by the following notice: "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose."

I further authorize the Division and its contractual agencies free exchange of information for the purpose of continuing care and health services review. I further authorize the Milwaukee County Behavioral Health Division to use the information regarding my care and treatment in conjunction with any and all educational training programs under affiliation agreements, and to the extent necessary to obtain and/or maintain licensure, accreditation, or certification.

ASSIGNMENT OF BENEFITS

I, hereby assign payment directly to the above named Division for the benefits otherwise payable to me by any third party, including major medical benefits, but not to exceed the regular charges for this period of hospitalization/emergency treatment/outpatient treatment. I (we) understand I am (we are) financially responsible for any regular charges not paid by said third party.

NOTICE OF DISCLOSURE

Information from your medical record will be shared, as permitted by law, with the State of Wisconsin Department of Health and Family Services.

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Behavioral Health Division has provided me a copy of its Notice of Privacy Practices.

☐ Patient **declines** copy of Privacy Practices Notice. ☐ Patient **declines** to sign form.

Patient's Signature (including minors over 14)	Date/Time	Witness Signature	Date/Time

Patient's Agent, Parent, or Guardian's Signature	Date/Time	Relationship

Addressograph or Name and BHD Number

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CONSENT FOR TREATMENT, RELEASE OF INFORMATION
ASSIGNMENT OF BENEFITS, NOTICE OF DISCLOSURE

6452 R20
Rev. 12/10

MEDICAL RECORD