Winona Health
855 Mankato Ave • Winona, MN 55987 • Phone 507.457.4476 • Fax 507.457.7672

Authorization for Disclosure of Health Information

Patient Information

Name: _____ Maiden/Former Name: _____

Street Address: _____ Date of Birth: _____

City, State, Zip: _____ Home/Cell Phone: _____

Release information *FROM*:

Name of Health Care/Provider: _____

Street Address: _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Release information *TO*: ☐ **Patient pick up** ☐ **Mail** ☐ **Other:** _____

Name of Health Care Provider/Plan/Other: _____

Street Address : _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Information to be released:	**Date of Service:**	**Information to be released:**	**Date of Service:**
☐ Clinic		☐ Operative/Procedure Report	
☐ EKG/EMG/EEG		☐ Pathology Report	
☐ Emergency Room		☐ Urgent Care	
☐ Hospital Records		☐ Radiology Reports	
☐ Immunizations		☐ Radiology Images	
☐ Labs		☐ Other:	

*** 2 year history provided unless specified above ***

If for an upcoming health care provider appointment, please provide the appointment date: _____

In compliance with Wisconsin and Minnesota Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol Abuse or test results ☐ Developmental Disabilities ☐ HIV, AIDS, or AIDS-related diseases

☐ Drug Abuse or test results ☐ Mental Health ☐ Sexually Transmitted Diseases

☐ Other: _____

This disclosure is being made for the following purpose(s):

☐ Further Medical Care ☐ Work Comp ☐ Relocation/Moving

☐ Insurance change ☐ Insurance ☐ Attorney/court case

☐ At the request of an individual ☐ Changing physicians ☐ Other: _____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Services Dept. **Right to Receive Copy of This Authorization** –I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Services Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE - This authorization is good for one year from the date signed unless otherwise specified: _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

If signed by anyone other than the patient, select the relationship/ authority below to do so and provide first and last name.

☐ Parent ☐ Guardian ☐ POA for Health Care ☐ Spouse/Adult Family Member of deceased patient

Print Name:

SIGNATURE: _____ **Date:** _____

OFFICE USE ONLY

Copies Given by: _____Initials:_____ Date: _____