

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:

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Date of Service:

<input type="checkbox"/> Clinic <input type="checkbox"/> EKG/EMG/EEG <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospital Records <input type="checkbox"/> Immunizations <input type="checkbox"/> Labs	<input type="checkbox"/> Operative/Procedure Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Urgent Care <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Other: _____
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*** 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:

<input type="checkbox"/> Alcohol Abuse or test results	<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> HIV, AIDS, or AIDS-related diseases
<input type="checkbox"/> Drug Abuse or test results	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Other: _____		

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

<input type="checkbox"/> Further Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Relocation/Moving
<input type="checkbox"/> Insurance change	<input type="checkbox"/> Insurance	<input type="checkbox"/> Attorney/court case
<input type="checkbox"/> At the request of an individual	<input type="checkbox"/> Changing physicians	<input type="checkbox"/> 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: _____