



Passion for excellence. Compassion for people.

Wausau, WI

Patient Label

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Previous last name(s) _____
Date of Birth _____ Social Security Number _____
Address _____
City, State, Zip Code _____ Phone # _____

I authorize the use and/or disclosure of my protected health information:

FROM:

TO:

Name _____
Organization _____
Address _____
City, State, Zip _____

Name _____
Organization _____
Address _____
City, State, Zip _____

Information to be disclosed includes (please initial):

____ All Clinic Records ____ Doctor Dictation ____ Neonatology ____ Other _____
____ Allergy Records ____ X-ray Reports ____ Lab Reports _____
____ Immunization Records ____ X-ray Films ____ EKG Reports _____
____ Nurse Notes ____ Perinatology _____

Dates of Service: _____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (please initial):

____ Mental Health ____ Developmental Disabilities ____ Alcohol &/ or Drug Abuse ____ HIV test results

Dates of Service (Specify): _____

Purpose for disclosure:

Medical Care Changing Physicians/
 Insurance Providers Disability Determination Social Services
 Legal Personal Worker's Compensation Other (Specify) _____

 Law Enforcement _____

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event: _____.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Patient Signature _____ **Date** _____

Signature of Parent/Legal Representative/Relationship _____ **Date** _____