



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name Address City State Zip
Date of Birth Daytime Phone Previous Name(s)

2) AUTHORIZES:

Name of Health Care Provider/Plan/Other
Address Fax # of Health Care Provider

3) TO DISCLOSE TO:

- Self, Delivery Options: Pick up Mail to address above View on-site Electronic Format
E-mail to:

If the e-mail address is shared with another person or the e-mail password is known to others, consider other method of delivery, HSHS will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g. a third party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g. virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e-mail. By selecting the unencrypted e-mail option I acknowledge the risks have been communicated and I accept these risks. Unencrypted Email

To be picked up by, I hereby authorize to pick up my records. (Photo ID required.)

Send To: Name of Health Care Provider/Plan/Other
Address Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From to If left blank, only information from the past two (2) years will be disclosed. (Month/Year) (Month/Year) Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

- Abstract of record/Pertinent records History & physical Discharge summary
Emergency Department report Consultation reports Operative reports
Radiology/Imaging reports Laboratory/Pathology EKG
Radiology/Imaging films/CD Progress notes Billing records

Specific records and/or information as follows:

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

- Alcohol/Drug Abuse HIV Test Results Mental Health/Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: Or if this item is left blank, the authorization will expire in (1) year from the date signed.

7) PURPOSE (check all that apply - copy fees may apply): Patient Request Continuing Care
Legal Investigation/Action Insurance Eligibility/Benefits Other:



8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights:** to inspect and/or receive a copy of the health information; to have information be used and/or disclosed by this Authorization; if I agree to sign this Authorization, I will be provided with a copy of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this Authorization; Authorization may be needed to release information to payers for certain mental health services, AODA services and/or HIV testing, I can refuse to sign this Authorization form for such purposes but I may be responsible for paying the entire bill for such services; I may revoke this Authorization at any time by notifying the authorization provider's health information department, as listed above, in writing and will not be effective as to uses and/or disclosures already made in reliance upon this Authorization, needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to a third party payers as provided in this Authorization after having provided treatment in reliance upon this Authorization; the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal privacy law. Wisconsin or Illinois Law *Federal Regulation (42 CFR, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy standards. I understand that if there is not an existing treatment provider relationship with the party to whom information is being sent, a general designation may be used. I understand that I may request a list of entities to which my information has been disclosed from the 'Send To' entity listed above.*

9) **SIGNATURE OF PATIENT:** _____ Date: _____ and/or
SIGNATURE OF PATIENT/LEGAL REP: _____ Date: _____
WITNESS SIGNATURE (AODA/Mental Health Only): _____ Date: _____

If signed by a person other than the patient, complete the following:

- 1) Individual is: a minor (AODA exception) legally incompetent or incapacitated deceased
 2) Legal authority: parent* legal guardian activated POA for Health Care next of kin/executor of deceased

*By signing above, I hereby declare that I have not been denied physical placement of this child.

OFFICE USE ONLY: Signature/ID verified: Yes No Date/Time Released: _____
 # of pages released: _____ Completed by: _____ Medical Record Number: _____
Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original