STOUGHTON HEALTH
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Date Copied/Sent:_____
Staff Initials:_____

PATIENT:

Name of Patient/Previous Names | Birth Date | Medical Record Number

Street Address | City, State, Zip Code

AUTHORIZES:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

INFORMATION TO BE RELEASED: (Check all that apply)

	Emergency/Urgent Care Records		Medical Imaging Reports (x-rays)		Day Surgery Records
	Occupational/Physical/Speech Tx		Medical Imaging Films		Inpatient Records
	Operative/Pathology Reports		Occupational Health Records		Alcohol/Drug Abuse Treatment
	Laboratory Reports		Cardiopulmonary Reports		Entire Record
	Other (specify)				

For the Following Date(s)_____

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

	Mental Health/Geriatric Psychiatry		Developmental Disabilities		Alcohol Abuse/Alcoholism
	HIV (AIDS)		Sexually Transmitted Disease		Drug Abuse
	Other (specify)				

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

	Further Medical Care		Legal Investigation or Action		Personal
	Insurance Eligibility/Benefits		Changing Physicians		
	Other (specify)				

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

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 Health Information Dept. **Right to Receive Copy of this Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that 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. **Right to Withdraw 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 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 until the following date(s) _____ or for one year from the date signed.

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.

SIGNATURE PATIENT/LEGAL REP.:_____**DATE**_____
(If signed by other than patient, state relationship & authority to do so.)