



Authorization for Use and Disclosure of Health Information

All sections must be completed for the authorization to be valid.

1. Entity releasing information:

(Name of person or organization)

(Street address)

(City/state/zip)

ATTN: _____

2. Name of patient/client/resident:

(Last)

(First)

(MI)

(Street address)

(City/state/zip)

(DOB)

(Alias)

(Med. Rec. #)

3. I hereby authorize the above entity to use and disclose the following protected health information.

Inpatient / Outpatient treatment

___ Clinic Notes

___ History & Physical

___ X-Ray Reports

___ Operative Records

___ Lab Reports

___ Other _____

___ Physical Therapy

HIV Testing and HIV treatment records

Developmental Disabilities

Sexually Transmitted Disease

Drug and/or Alcohol Abuse

Mental Health

Dates _____

Dates _____

Certain persons and organizations have access to my health information regarding HIV testing and HIV treatment. By Wisconsin state law I may obtain a list of these persons and organizations upon request.

4. Please release this information to the following:

(Name of person or organization)

(Street address)

(City/state/zip)

ATTN: _____

5. The Purpose or need for disclosure is:

Further medical care

Date of appointment _____

Application for insurance

Payment of Insurance claim

Legal purposes

Other _____

6. I understand my rights in regards to the authorization.

- I will receive a copy of this authorization.

- I may inspect or copy the information I have authorized to be used or disclosed by making arrangements with Health Information Services.

- Authorizing this use or disclosure of information is voluntary. I do not need to sign this form to ensure healthcare treatment.

- I may revoke/withdraw this authorization at any time by written notice to Health Information Services. This will not be effective until received by MMC and will not apply to information that has already been released in response to this authorization. I understand this will not apply in certain cases with insurance companies who may have the right under law to contest a claim under my policy.

7. This authorization is valid to: the following date/event _____ OR six (6) months from the date signed.

8. The information disclosed, may be redisclosed by the recipient and the information may not be covered by federal privacy laws and regulations.

9. SIGNATURE _____ DATE _____

If signed by person other than the patient/client/resident, state reason, relationship and authorization to do so.

Reason: Minor Incompetent Disabled Deceased

Relationship: Legal Guardian (attach proof of court action) Authorized legal representative Parent of minor

Custodial Patient Next of kin of deceased (must be spouse if living) Executor of Estate of Deceased

WITNESS _____

DATE _____