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Memorial Medical Center
Neillsville, Loyal, Greenwood
Care...at its best

Authorization for Use and Disclosure of Health Information

All numbered 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:

____
(Last) (First) (MI)

____
(Street Address)

____
(City/state/zip)

____
(DOB) (Alias) (MR#)

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

- ☐ Medical Notes/Summaries
- ☐ X-Ray Reports
- ☐ Lab Reports
- ☐ Physical Therapy
- ☐ Other _______________________________
- ☐ HIV Testing and treatment records
- ☐ Developmental disabilities
- ☐ Sexually Transmitted Disease
- ☐ Drug and/or Alcohol Abuse
- ☐ Mental Health

4. Dates requested _______________________________ (If not completed, last 2 years will be sent.)

5. Please release this information to the following:

____
(Name of person or organization)

____
(Street Address)

____
(City/State/Zip)

ATTN: ____________________ Fax # ____________________

6. The purpose or need for disclosure is:

- ☐ Further medical care
- ☐ Sharing info
- ☐ Insurance purposes
- ☐ Self
- ☐ Legal purposes

7. If not revoked, this authorization is valid until it expires six months from the date signed below or until the following date or event:

____

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.
- Certain persons and organizations have access to my health information regarding HIV testing and treatment. By Wisconsin state law I may obtain a list of these persons and organizations upon request.
- The information disclosed may be redisclosed by the recipient and the information may not be covered by federal privacy laws and regulations.
- By signing this authorization, I am confirming that it accurately reflects my wishes.

8. SIGNATURE: _______________________________ Date: ____________________

If signed by person other than the patient/client/resident, check appropriate box:
☐ Legal Guardian (attach proof of court action) ☐ Authorized legal representative ☐ Parent of Minor
☐ Next of kin of deceased (must be spouse if living) ☐ Executor of Estate of Deceased