

Authorization for Use and Disclosure of Protected Health Information

Name of Patient	Maiden or Previous Name	Date of Birth
Street Address		City, State, Zip Code
Phone Number: (Home)	(Work)	(Other)

AUTHORIZE:		RELEASE RECORDS TO:	
Name of Physician/Healthcare Facility	Name of Physician/Healthcare Facility	Name of Physician/Healthcare Facility	Name of Physician/Healthcare Facility
Street Address	Street Address	Street Address	Street Address
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone #	Fax #	Telephone #	Fax #

Information to be Released:

Date Range: From: _____ To: _____

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Results/Pathology Reports	<input type="checkbox"/> Letters
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> OB Records
<input type="checkbox"/> ER Reports	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Operation Reports
<input type="checkbox"/> Hospital Admissions	<input type="checkbox"/> X-ray Films/CD	<input type="checkbox"/> Consultations
<input type="checkbox"/> Hospital Observations	<input type="checkbox"/> Other: _____	

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

<input type="checkbox"/> Substance abuse (including alcohol/drug abuse)	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Psychotherapy notes	<input type="checkbox"/> HIV-related information (including AIDS related testing)

The confidentiality of this record is required under WI Statute §252.12 and §252.15, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient or Legal Guardian _____ Date _____

Reason for Disclosure:

I would like this information released for the following purpose:

<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Insurance purposes	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Attorney	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other _____

If leaving our clinic- Reason:

<input type="checkbox"/> Dissatisfaction	<input type="checkbox"/> Moving	<input type="checkbox"/> Insurance
<input type="checkbox"/> Convenience of Hours	<input type="checkbox"/> Convenience of Location	<input type="checkbox"/> Other _____

I have read and understand the following:

- ❖ This authorization expires one year after I sign it or sooner (specify here: _____). This time period noted here may exceed one year only in certain situations specified by law.
- ❖ I may revoke this authorization at any time by notifying the facility in writing that I have authorized to release my records and this authorization will cease to be effective on the date notified. This will not apply to records that have already been released.
- ❖ The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information. Once the records are released, Osceola Medical Center can not prevent them from being released to a third party.
- ❖ There may be a fee for releasing these records.
- ❖ To be valid, this authorization must be filled out completely and signed. A copy is valid if it has not been altered.
- ❖ If I do not sign this authorization, my healthcare and payment for my healthcare will not be affected, and will not jeopardize my right to obtain present or future treatment, except where disclosure of the information is required for the treatment.

Signature of patient or authorized person	Authorized person's authority to sign	Date
(If authorized person is signing, please also print name)	(parent, guardian, power of attorney, etc.)	

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____

*****Photo ID is required to pick up records/films*****