P.O. Box 387
Portage, WI 53901-0387
(608) 742-4131

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Regarding Patient:

Name ______________________ Date of Birth ______________ MR Number ______________

Address ______________________ Phone Number ______________________

City, State, Zip Code ______________________ Social Security Number ______________________

2. Records Released From:

Individual(s)/agency/organization making disclosure ______________________

Street Address ______________________

City, State, Zip Code ______________________

Phone number ______________________

3. Records Released To:

Individual/agency/organization receiving information ______________________

Street Address ______________________

City, State, Zip Code ______________________

Phone number/fax number ______________________

4. Type or extent of information to be disclosed:

☐ Discharge Summary ☐ History and Physical ☐ Operative Report ☐ Laboratory reports ☐ Radiology reports

☐ Physician Clinic Notes ☐ Rehab Reports ☐ Emergency Room Record ☐ EKG ☐ All records

☐ Overview of all records (contains all Discharge Summaries, Op Notes, Path reports, Clinic summaries, X-ray, EKG and lab reports from last five years)

☐ Other ____

____

5. The records to be disclosed may include the following: [Check all that apply and initial after each check]

☐ Mental Health/psychiatric ________ ☐ Alcohol &/or Drug Abuse ________ ☐ HIV/AIDS test results ________

[Wisconsin Statutes 51.30 and 252.15 require specific consent for the release of information regarding treatment for the following: Alcohol and drug Treatment or Evaluations, AIDS/AIDS related illnesses and HIV status, and any psychiatric services.]

6. For the following date(s) or timeframe: From ______________ To ______________.

7. Purpose for the need of disclosure: (Check applicable categories)

☐ Patients own use ☐ Legal council ☐ Workers Comp ☐ Payment of Claim

☐ Continuity of Care ☐ Coordinating Care for Dependent/Spouse ☐ Insurance Eligibility/Benefits

☐ Other (Specify): ____.

8. Redisclosure notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

9. Expiration date: This authorization is good for one year or until (indicate date) ______________________

10. By signing this authorization, I am confirming that it accurately reflects my wishes. I authorize the release of my medical record in accordance with the specification listed above. A copy or facsimile of this authorization is as valid as the original. The reverse side of this form outlines my rights regarding this authorization.

Signature of Patient / Legal Rep: ______________________ **Date & Time:** ______________

(If signed by other than individual, state relationship with signature)

☐ HCPOA for patient ☐ Parent or legal guardian of minor ☐ Other (specify): ______________________

Information Released by: ☐ Telephone ☐ Fax ☐ Mail ☐ Other ______________

Employee Releasing Information: ______________________ **Date & Time** ______________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Divine Savior Healthcare may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. (Note: WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.)

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to a Divine Savior Healthcare Correspondence Technician. I am aware that my withdrawal will not be effective until received by the Correspondence Technician and will not be effective regarding the uses and/or disclosures of my health information that Divine Savior Healthcare has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Marketing: I understand if Divine Savior Healthcare uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 Divine Savior Healthcare's Privacy Officer or a Correspondence Technician.

HIV test results: I understand my HIV test results may be released without authorization to persons/organizations that have access under State law.