

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip, Phone Number

AUTHORIZES DISCLOSURE BY:

DISCLOSURE OF HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Report-Films | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Rehab Notes |
| <input type="checkbox"/> ED Report | <input type="checkbox"/> Other: _____ | | |

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- HIV/AIDS* Mental/Behavioral Health Conditions Drug/Alcohol Abuse/Treatment

FOR THE FOLLOWING DATES: From: _____ To: _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Transfer to New Provider | <input type="checkbox"/> Insurance/Claim Purposes | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Vocational Rehab Eval |
| <input type="checkbox"/> Other: _____ | | | |

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I must be provided with a copy. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that Ministry Health Care 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.** **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 Ministry Health Care. 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. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. ****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.**

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 and authority to do so.)

FOR ORGANIZATIONAL USE

Dt Received:	Dt Disclosed:	Processed By:	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed	<input type="checkbox"/> Picked Up By:
--------------	---------------	---------------	---------------------------------	--------------------------------	--