

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Previous last name(s) _____
 Date of Birth _____ Social Security Number _____
 Address _____
 City, State, Zip Code _____ Phone # _____

I authorize the use and/or disclosure of my protected health information:

FROM:	TO:
Name _____	Name _____
Organization _____ Aspirus Wausau Hospital	Organization _____
Address _____ 333 Pine Ridge Boulevard	Address _____
City, State, Zip _____ Wausau, WI 54401	City, State, Zip _____

Information to be disclosed includes (please initial):

_____ Discharge Summary	_____ Lab Reports	_____ X-ray Reports	_____
_____ History & Physical	_____ Emergency	_____ X-ray Films	_____
_____ Operative/Pathology Report	_____ Department Record	_____ Verbal Exchange	_____
		_____ Other _____	

Dates of Service: _____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (please initial):

_____ Mental Health _____ Developmental Disabilities _____ Alcohol &/ or Drug Abuse _____ HIV test results

Dates of Service (Specify): _____

Purpose for disclosure:

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Changing Physicians/ Providers | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Legal | | <input type="checkbox"/> Law Enforcement | _____ |

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right To Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event: _____

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Signature of Patient _____ **Date** _____

Signature of Parent/Legal Representative/Relationship _____ **Date** _____