ASPIRUS™ CLINICS

Passion for excellence. Compassion for people.

Patient Label

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Previous last name(s) _____

Date of Birth _____ Phone Number _____

Address _____

City, State, Zip Code _____

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

FROM:	TO:
Name _____	Name Aspirus Cardiology
Organization _____	Organization _____
Address _____	Address 500 Wind Ridge Drive
City, State, Zip _____	City, State, Zip Wausau, WI 54401
Phone Number _____ Fax Number _____	Phone Number _____ Fax Number _____

Information to be disclosed includes *(please initial)*:

_____All Clinic Records	_____Doctor Dictation	_____Neonatology	_____Other _____
_____Allergy Records	_____X-ray Reports	_____Lab Reports	_____
_____Immunization Records	_____X-ray Films	_____EKG Reports	_____
_____Nurse Notes	_____Perinatology		_____

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:

☐ Medical Care	☐ Changing Physicians/ Providers	☐ Disability Determination	☐ Social Services
☐ Insurance		☐ Worker's Compensation	☐ Other (Specify) _____
☐ Legal	☐ Personal	☐ 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.

Patient Signature _____ ***Date*** _____

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