AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

AUTHORIZES: (Who has the information you want released?)

Name of Health Care Provider/Plan/Other _____

Street/Mailing Address _____

City, State, Zip Code _____

Telephone Number _____

Fax Number _____

TO DISCLOSE TO: (Where do you want the information sent?)

Name of Patient/Health Care Provider/Plan/Other _____

Street/Mailing Address _____

City, State, Zip Code _____

Telephone Number _____

Fax Number _____

INFORMATION TO BE RELEASED: For the following date(s): From: _____ to _____

_____ History & Physical Exam
_____ Discharge Summary
_____ Operative Report
_____ ER Records
_____ Clinic Progress Notes
_____ Consultations
_____ Immunizations
_____ Other (specify) _____
_____ X-Ray Imaging Studies
_____ X-Ray/Diagnostic Imaging Reports
_____ Laboratory/Pathology Reports
_____ PT/OT Notes
_____ EKG/Special Diagnostic Reports

PLEASE COMPLETE THIS SECTION IF APPLICABLE: IF NOT, ENSURE "NOT APPLICABLE" is checked below. In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

The following Date(s): **From:**_____**to** _____

_____ Mental Health
_____ HIV (AIDS)
_____ Other (Specify): _____
_____ Developmental Disabilities
_____ Sexually Transmitted Diseases
_____ Alcoholism
_____ Drug Abuse
_____ Not Applicable

PURPOSE OF DISCLOSURE: (CHECK APPLICABLE CATEGORIES)

_____ Further Medical Care
_____ Insurance Eligibility/Benefits
_____ Other: _____
_____ Vocational Rehabilitation Evaluation
_____ Legal Investigation or Action
_____ Personal
_____ Changing Physicians

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy 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 Baldwin Area Medical Center's privacy officer. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition to treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Baldwin Area Medical Center's Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the Baldwin Area Medical Center has already made in reference to this authorization.
REDISCLOSURE STATEMENT: BAMC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release BAMC from any and all liability resulting from a redisclosure by the recipient.
I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am authorizing Baldwin Area Medical Center to disclose my above identified protected health information.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

IF NOT PATIENT, PLEASE STATE RELATIONSHIP TO PATIENT: _____

WITNESS: _____ **EXPIRATION DATE:** 90 days after signature

Completion Date: _____ **Clinic/Nursing Staff (Initials):** _____ **ROI/HIM Staff (Initials):** _____ **Photo ID:** _____