WESTERN WISCONSIN HEALTH

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

I AUTHORIZE: ☐ **TO RELEASE RECORDS TO/** ☐ **TO OBTAIN RECORDS** FROM

Western Wisconsin Health
Name of Provider/Healthcare Facility

Name of Person/Health Care Provider/Person/Plan

1100 Bergslien Street
Street/Mailing Address

Street/Mailing Address

Baldwin, WI 54002
City, State, Zip Code

City, State, Zip Code

715-684-1590 **715-684-**
Telephone # Fax#

Telephone # Fax#

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

I have read and understand the following:

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. To do so, I may contact Western Wisconsin Health's privacy officer.

I understand that I am under no obligation to sign this form, however if I agree to sign this authorization, I must be provided with a signed copy of the form. 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. I have the right to withdraw this authorization at any time by contacting Western Wisconsin Health's privacy officer in writing. My withdrawal will not be effective as to uses and/or disclosures that Western Wisconsin Health has already made in reference to this authorization.

REDISCLOSURE STATEMENT: Western Wisconsin Health 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 Western Wisconsin Health 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 Western Wisconsin Health to disclose my above identified protected health information.

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

IF NOT PATIENT, PLEASE STATE RELATIONSHIP TO PATIENT: _____
(PARENT, GUARDIAN, POA, ETC)

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

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