



# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient/Previous Names \_\_\_\_\_

Birth Date/Medical Record Number \_\_\_\_\_

**AUTHORIZES: (name of releasing organization)** \_\_\_\_\_

**TO DISCLOSE TO:** \_\_\_\_\_

Name of Health Care Provider/Plan/Other \_\_\_\_\_

Name of Health Care Provider/Plan/Other \_\_\_\_\_

Street/Mailing Address \_\_\_\_\_

Street/Mailing Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

**For the following date(s): From:** \_\_\_\_\_ **To:** \_\_\_\_\_

- History & Physical Exam
- Discharge Summary
- Operative Reports
- 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: 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 Disease
- Alcoholism
- Drug Abuse

**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 AUTHORIZATION:**

**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 treatment, payment, enrollment in a health plan or eligibility for health care 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.

**REDISCLASURE STATEMENT:** I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy rules.

**EXPIRATION DATE:** This authorization will expire 90 days after the date signed.

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:** \_\_\_\_\_