sauk prairie HEALTHCARE

260 26th St, Prairie du Sac, WI 53578
608-643-3311

**PICK ONE _____ Mail _____ Pick up **Need by _____

Records given to patient _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____
Name of Patient/Previous Names

_____
Street Address

_____
City, State, Zip Code

_____
Date of Birth

Disclose Information To:

☐ Person completing this form --or--

_____
Name of HealthCare Facility or Provider/Family Member/Other

_____
Street Address

_____
City, State, Zip Code

Disclosure By:

- ☐ Sauk Prairie Hospital
- ☐ Wisconsin Heights Clinic
- ☐ Lodi Clinic
- ☐ Plain Clinic
- ☐ River Valley Clinic
- ☐ Orthopedic Associates
- ☐ Surgical Associates
- ☐ Other

Information Disclosed: identify below the specific information to be disclosed along with relevant dates of service.

- ☐ Emergency Room Report
- ☐ Lab Reports
- ☐ Discharge Summary
- ☐ X-Ray Reports/Films
- ☐ History & Physical
- ☐ Complete Record
- ☐ Other: _____

Approximate Date(s) of Service: _____

Purpose for Disclosure:

- ☐ Further Medical Care
- ☐ Application for Insurance
- ☐ Disability Determination
- ☐ Personal Use
- ☐ Payment of Insurance
- ☐ Legal Use

Expiration: This medical release is good one time only unless otherwise specified

- ☐ Expires or Revokes on: _____
- ☐ On occurrence of the following event: _____

I have been given the opportunity to review and understand the content of this authorization form. By signing this, I am confirming that it accurately reflects my wishes. I agree that a photocopy of this authorization shall be as valid as the original. This also includes disclosure of releasing special documents related to testing, diagnosis and treatment of conditions.

Signature of Patient/Legal Rep: _____ ***Date:*** _____

Relationship to the patient:

- ☐ Parent/Legal Guardian
- ☐ POA
- ☐ Next of Kin

Signature of Patient/Legal Rep: _____ ***Date:*** _____

Diagnosis, Treatment and Testing of Special Condition of:

- ☐ HIV/AIDS
- ☐ Mental/Behavioral Health
- ☐ Drug/Alcohol Abuse

See Back of page for YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or receive a copy of the Health Information to be used or disclosed- I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. **Right to receive a copy of this authorization**- I understand that if I agree to sign this authorization, which I am not required to do, I will 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 healthcare benefits on my decision to sign this authorization. **Right to Withdraw this authorization**- I understand that 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 Sauk Prairie Healthcare. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. Sauk Prairie HealthCare will not condition treatment on the completion of this authorization. I understand that, once my health information leaves the control of Sauk Prairie HealthCare, it may be further disclosed by the receiving party. I agree that I will not hold Sauk Prairie HealthCare liable for re-disclosure of the health information I have authorized that are made by the recipient named in this authorization.