AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original.

PATIENT

Patient Name/ Previous Names associated with Patient

Date of Birth or Medical Record Number

Street Address

City /State/Zip Code

AUTHORIZES:

INFORMATION TO BE RELEASED FROM: **INFORMATION RELEASED TO:**

Name of Health Care Provider/Plan/Other:	Name of Receiver:
Street Address:	Street Address:
City/State/Zip Code:	City/State/Zip Code:
	Fax Number:

INFORMATION TO BE RELEASED INCLUDES:

____History& Physical (dates/type)_____

____Discharge Summary (dates/type)_____

____Consultations (dates/type)_____

____Operative Reports

____Doctors progress notes: dates/type_____

____Other: _____

____ER reports:

____X-ray reports

____Lab Reports

*** Please note x-ray films and pathology slides are not kept at Wisconsin Institute of Surgical Excellence**

NEED FOR THE DISCLOSURE:

____Changing Physicians/Relocation/Moving

____Consultation/Further Medical Care

____Disability Determination

____Vocational Rehab Evaluation

____Worker's Comp Injury

____Legal Investigation

____Court Case

____Personal

____Payment Process /Insurance/Billing difficulties

____Application for Insurance

____Other:

_____

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

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 the health information department. **Right to Receive Copy of this Authorization—**I understand that if I agree to sign this authorization, which I am not required to do so, 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 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 the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s)_____or for one year from the date signed. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REPRESENTATATIVE:

_____

-DATE: _____ **(**If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: _____ (Employee) Date: _____ Records Released:

_____