Consent for Use and Release of Health Information

This consent applies to all Western Wisconsin Health locations where I may receive my care.

Treatment, Payment and Operations: I authorize Western Wisconsin Health, any other health care providers, entities that pay for my health care, and anyone affiliated with or authorized by them to release and receive my health records and other information about my health care for treatment, payment and health care operations purposes as described in Western Wisconsin Health's Notice of Privacy Practices. I understand that information received by or created in a drug or alcohol abuse treatment unit may require another authorization before it can be released for some or all of these purposes.

Provider Record Locator or Patient Information Service: A health record locator or patient information service helps my health care providers know where I have received care and get information about my health to help treat me. Western Wisconsin Health and other providers who participate in a record locator or patient information service may access my information in a record locator or patient information service to help provide care and services to me. Western Wisconsin Health may share my identifying information and location of my health records with a health record locator or patient information service, unless I check here: ☐

Consent for Use and Disclosure of Medical Records In Research: I authorize Western Wisconsin Health to use or disclose my medical records for research. This includes health records created by Western Wisconsin Health and any records Western Wisconsin Health receives from other health care providers while treating me, unless I check here: ☐

This consent will continue forever unless I cancel it in writing at:

Western Wisconsin Health
Health Information Management
1100 Bergslien Street
Baldwin, WI 54002

If I cancel my consent, it will not change releases that have already been made.

______________________________	______________
Patient or Legal Representative Signature	Date / Time
______________________________	______________
Legal Representative Printed Name (if signing for patient)	Authority to Sign for Patient (Attach Documentation)

Please Place a Current Admission Sticker Here When Available

Patient Name: ____________________

Date of Birth: __________ Med Rec #: __________

8.2017 klj