WESTERN WISCONSIN HEALTH

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1100 Bergslien Street • Baldwin, WI 54002 • Health Information Management Department • Phone 715-684-1590 • Fax 715-684-1594

Patient Information:

Patient name: _____ Date of Birth: _____
Previous name(s): _____ MRN: _____
Address: _____ Phone: _____
City: _____ State: _____ ZIP: _____

Health Information Released FROM:

*(**Who** has the information you want released?)*

☐ Western Wisconsin Health
OR
☐ Other – Person/Organization: _____
Attn/Department: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ ZIP: _____

Health Information Released TO:

*(**Where** do you want the information sent?)*

☐ Western Wisconsin Health
OR
☐ Other – Person/Organization: _____
Attn/Department: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ ZIP: _____

Health Information to be Released:

*(**What** information do you want sent or released? Check the appropriate box)*

Indicate date(s) of service: _____

Routine Record Sets: ☐ Clinic encounter(s) ☐ Hospital encounter(s)

Send CHECKED Records only:

			Behavioral Health Specific:
☐ Discharge Summary	☐ Radiology reports	☐ Medication/Allergy record	☐ Intake Assessment
☐ Operative report	☐ Laboratory reports	☐ Immunizations	☐ Treatment Plan
☐ History & Physical	☐ Pathology reports	☐ Billing Records	☐ Psychological Testing
☐ Emergency records	☐ Diagnostic Test results	☐ Copies of Films/Images	☐ Psychiatric Evaluation
☐ Progress Notes	☐ Rehab records (PT/OT/ST)	☐ Other: _____	

All records pertaining to Behavioral/Mental Health, HIV/HIV related illness and Alcohol and/or drug abuse will be released unless indicated here. Do **NOT** release records/information related to:

☐ Behavioral/Mental Health ☐ HIV/HIV related illness ☐ Alcohol and/or drug abuse

Purpose of Disclosure:

*(**Why** is it needed?)*

☐ Continuity/Transfer of Care ☐ Personal use or review ☐ Changing Clinics
☐ Referral ☐ Insurance or Disability Determination ☐ Dissatisfied with Care
☐ Legal/Attorney ☐ Other: _____ ☐ Moving Out of Area

Release Instructions:

*(**How** and **When** do you want the information?)*

Date information is needed: _____ **(NOTE: PLEASE ALLOW 7 BUSINESS DAYS FOR PROCESSING)**

Delivery / Format method:

☐ Mail – Paper ☐ Pick up – Paper ☐ Fax – Paper
☐ Mail – PDF on USB Drive ☐ Pick up – PDF on USB Drive ☐ MyChart – PDF sent to MyChart
☐ Mail – CD (only for Imaging) ☐ Pick up – CD (only for Imaging) ☐ Other: _____

I have read and understand the following rights with respect to this authorization:

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- 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 can be provided with a signed copy of the form upon request.
- 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 (WWH) has already made in reference to this authorization.
- I understand that I am under no obligation to sign this form and that WWH may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this form.
- WWH 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 WWH 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 WWH to disclose my above identified protected health information.

Signature requirements:

_____ _____
Patient/Legal Representative's Signature (include relationship if other than patient) Date

OFFICE USE ONLY: Completion Date: _____ Clinic/Nursing Staff (Initials):_____ ROI/HIM Staff (Initials): _____ Photo ID: _____