#

# WISCONSIN HEALTH FUND MEDICAL CENTER

##### 6200 W. BLUEMOUND RD., MILWAUKEE, WISCONSIN 53213, 414-771-5600

### AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

#### INDIVIDUAL AUTHORIZING RELEASE OF PROTECTED HEALTH INFORMATION

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THERE MAY BE A CHARGE FOR MEDICAL RECORDS RELEASED DIRECTLY TO THE PATIENT**

**ALL INFORMATION ON THIS FORM MUST BE COMPLETE OR RECORDS WILL NOT BE SENT/RECEIVED.**

 Patient Name (Please Print)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip Code

**AUTHORIZE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO RELEASE THE FOLLOWING INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

**[ ]** Lab Results For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** MD Notes For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** X-ray Reports For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** X-Ray Films/CD For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** Physical Therapy Notes For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** Chiropractic Notes For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Claims History For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other – please provide a specific description of the information you want released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In accordance with Wisconsinlaw that requires special permission to release certain protected information, I,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the release of the following information:

[ ]  Mental Health Records For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Developmental Disability For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  HIV Test Results For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Alcohol/ Drug Abuse For dates of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PLEASE CONTINUE ON BACK →

**TO THE FOLLOWING PERSON/ ENTITY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/ Entity who should receive the information you want released

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

**FOR THE FOLLOWING PURPOSE:**

[ ]  Continuation of Care [ ]  Insurance Eligibility/ Benefits [ ]  I elect not to provide a statement of purpose

[ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**You have the right to a copy of this authorization once you have signed it.**

**You have the right to withdraw this authorization at any time by providing a written statement to Wisconsin Health Fund's Privacy Officer.** However, your withdrawal will not be effective until it is received by Wisconsin Health Fund’s Privacy Officer and will not be effective in regard to any use/disclosure that Wisconsin Health Fund made prior to receipt of your request to withdraw authorization. If the authorization was obtained to obtain insurance coverage, the law provides the insurer with the right to contest a claim under the policy or to contest the issuance of the policy itself.

**You have the right to inspect and copy the health information that is to be disclosed**, except for psychotherapy notes, information compiled in reasonable anticipation of a legal proceeding and information subject to the Clinical Laboratory Improvement Amendments of 1988 to the extent that you would be prohibited from accessing the information by law.

**You have the right to refuse to sign this authorization.** Withoutyour authorization Wisconsin Health Fund cannot release your protected health information except as provided by law. Wisconsin Health Fund may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision not to sign this authorization except 1) Wisconsin Health Fund may condition enrollment in the health plan and eligibility for benefits on providing an authorization which Wisconsin Health Fund requested prior to your enrollment in the health plan if the authorization is not for psychotherapy notes and is sought to determine health plan eligibility, enrollment determinations for you or for Wisconsin Health Fund's underwriting and risk rating determinations; Wisconsin Health Fund may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on your granting an authorization for disclosure of the information to such a third party; 3) for research related treatment.

**Re-Disclosure Notice:**

The information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by privacy standards established by law.

This information may be sent via fax when necessary.

**Expiration Date:**

This authorization is valid a **Maximum of 1 year** from the date it is signed by the patient.

FORMAT REQUESTED: [ ]  IN-PERSON PICKUP [ ]  PAPER [ ]  CD [ ]  ENCRYTED EMAIL

**Signature of Person Authorizing Release of Information:**

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

**Initial of Staff Reviewing/ Accepting Form:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  **CHECK ID**



Wisconsin Health Fund Medical Center 6200 W. Bluemound Road, Milwaukee, WI 53213 Phone 414-771-5600