

Patient Name: LAST FIRST MI

Date of Birth

Medical Record Number

I hereby authorize:
(Name and address of releasing facility)

To Release Information to:
(Individual name, facility/organization and address)

Date & Time of Appointment

Including attached addendum

PURPOSE OF DISCLOSURE:

- Continuing Care
Payment of Claim
School
Worker's Compensation
Legal
For Personal Use
Other (specify):

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

Initial

Do not release Alcohol and/or Drug Abuse information

Do not release Behavioral Health information

INFORMATION TO BE RELEASED:

Between Dates of: to

- Discharge Summary
H&P Exam/Initial Evaluation
Consult
CD Counselor/Therapist Reports
Progress Notes/Provider Notes
Orders
Other (specify content and dates):
X-Ray Reports
X-Ray Films/MRI
Diagnostic Test Reports
Procedure Reports
Lab Reports/Pathology
Correspondence
Psychiatric Testing
Transfer/Outside Information
Completed Form
Exchange of Verbal Communication
HIV related information (AIDS related testing)

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is ___ or 1 year from today's date, whichever is sooner.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
I understand that SMDC may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
I understand I will receive a copy of this form after I have signed it.
I understand that in compliance with MN Statute 144.335 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
I understand a photocopy or fax of this form is the same as the original.
I understand that: (1) my HIV test results may be released without my authorization to persons/ organizations that have access under Wisconsin law; and that (2) a list of those persons/ organizations is available upon request.

If I am signing as Authorized Representative of the patient, I am:

- Parent of minor
Court appointed guardian/conservator

Patient Signature

Date

Signature of Authorized Person

Relationship to Patient



AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

ITEM # 39275

AUTH.001 Orig: 04/03 Rev: 12/04, 11/05, 5/06