AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Patient Name/Previous Name(s) *Date of Birth*

_____ _____
Street Address *City, State, Zip Code*

AUTHORIZES FROM:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

For the following dates: ___/___/___ to ___/___/___

INFORMATION TO BE RELEASED:

_____Medical History, Examination, Reports _____ Surgical Reports _____ Immunizations

_____ Treatment or Tests _____Hospital Records/Reports _____Radiology Reports _____ Laboratory Reports

_____Consultations _____ Other _____

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

_____Mental Health _____Developmental Disabilities _____ Alcohol & Other Drug Abuse

_____HIV (AIDS) _____Sexually Transmitted Disease Results _____Clinic Therapy (counseling) Notes

_____Mental Health Admission/Discharge Summary _____Mental Health Hospital Assessments/Notes

PURPOSE OF DISCLOSURE:

_____Further Medical Treatment _____ Legal Investigation/Action _____Personal

_____Insurance Eligibility/Benefits _____Changing Physicians

_____Other _____

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 Oakleaf Clinic, SC. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may 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) 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. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records:
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CRF Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

Note: A patient (18 years or older) must authorizes the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

_____ _____
Signature of Patient or Legal Representative *Date*

_____
Relationship (if not patient)

_____ _____
Witness *Date*