

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)

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

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

Including attached addendum

Date & Time of Appointment \_\_\_\_\_

**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 \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Discharge Summary                              | <input type="checkbox"/> X-Ray Reports           | <input type="checkbox"/> Psychological Testing                    |
| <input type="checkbox"/> H&P Exam/Initial Evaluation                    | <input type="checkbox"/> X-Ray Films/MRI         | <input type="checkbox"/> Transfer/Outside Information             |
| <input type="checkbox"/> Consult  | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Completed Form                           |
| <input type="checkbox"/> CD Counselor/Therapist Reports                 | <input type="checkbox"/> Procedure Reports       | <input type="checkbox"/> Exchange of Verbal Communication         |
| <input type="checkbox"/> Progress Notes/Provider Notes                  | <input type="checkbox"/> Lab/Pathology Reports   | <input type="checkbox"/> Correspondence                           |
| <input type="checkbox"/> Orders   | <input type="checkbox"/> Pathology Slides        | <input type="checkbox"/> Other (specify content and dates): _____ |
| <input type="checkbox"/> 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 any time 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

White – Organization

Yellow – Patient

AUTH.001 Orig: 04/03 Rev: 12/04, 11/05, 6/06, 3/07, 1/11