

Patient Label

**All bolded information must be filled in prior to obtaining records.**

**Name Of Patient:** \_\_\_\_\_

Address \_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Med Rec # \_\_\_\_\_

**I authorize St. Mary's Hospital Medical Center to:**  Release to \_\_\_\_\_ and/or  Obtain From \_\_\_\_\_

**Individual/agency/organization receiving/releasing information:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**I request the following Information:** \_\_\_\_\_

\_\_\_\_\_

In compliance with WI Statutes, which require specific permission to release confidential information, please release records pertaining to: **(Check All That Apply)**

- Mental Health       HIV Test Results       Alcohol and/or Drug Abuse  
 Developmental Disabilities       Other

**For the Date(s): From** \_\_\_\_\_ **To** \_\_\_\_\_

**Purpose of disclosure: (check all that apply)**

- Personal Use       Legal  
 Employer Use       Further Medical Care  
 Insurance Eligibility/Benefits       Other (Specify) \_\_\_\_\_  
 Claims Resolution

**HOSPITAL USE ONLY**

Report Type	Date of Rpt	Report Type	Date of Rpt	Report Type	Date of Rpt
Abstract		EEG		Newborn ID Sheet	
Anesthesia		EKG		Lab	
Cardiac Cath CD's		EMG		OR/Procedures	
Consult		Entire Record		Pathology	
Diagnostic Serv. Films		ER Record		Physicians Orders	
Diagnostic Serv. Rpts		ED Dictation		Progress Notes	
Disch Instructions		Financial Sheet		Pulmonary Function	
Disch Summary		H & P			

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

**SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:** \_\_\_\_\_ **Date** \_\_\_\_\_

- (Check if applies)  Parent of Minor  
 Power Of Attorney for Health Care (Legal Document Attached)  
 Next of kin of deceased (spouse, if living)  
 Legal Guardian (letters of appointment)

(OVER)

**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

Patient Label
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**DOB:** \_\_\_\_\_

**Name Of Patient:** \_\_\_\_\_ **Medical Record #** \_\_\_\_\_

**Your rights with respect to this authorization:**

I understand if I sign this authorization, I will be provided with a copy of the authorization upon request. I understand that I am under no obligation to sign this form and that St. Mary's Hospital Medical Center may not disclose my condition, treatment, payment, enrollment in a health plan or eligibility for health care based benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, and/or c) the provision of health care that is solely for the purpose of creating PHI (Protected Health Information) for disclosure to a third party.

I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to St. Mary's Hospital Medical Center. I am aware that my withdrawal will not be effective until received by St. Mary's Hospital Medical Center and will not be effective regarding the uses and/or disclosures of my health information that St. Mary's Hospital Medical Center has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand 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 the Health Information Management Department.

I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

**REDISCLASURE NOTICE:** I understand information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

**EXPIRATION DATE:** This authorization only refers to this date of my signing. By signing this authorization, I am confirming that it accurately reflects my wishes and does not refer to future visits.

**Hospital Use Only:**

- |   |                                       |                                      |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Verbal Release       | <input type="checkbox"/> Paper Copies | <input type="checkbox"/> CD's        |
| <input type="checkbox"/> Verbal Phone Release | <input type="checkbox"/> Electronic   | <input type="checkbox"/> Other _____ |
|   | <input type="checkbox"/> Films        |                                      |

Prepared by: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

Released by: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

Identification Checked:  photo ID  SS#  \_\_\_\_\_  
Other

**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**