Authorization for Release of Patient-Identifiable Health Information

patient name _____

birthdate _____/_____/_____

By completing the nine numbered sections below, I authorize the use or disclosure of the above-named individual's health information as described.

① To be released by:

_____
name of physician / health care facility

_____
street address

_____
city / state / zip

② To be released to:

PRAIRIE CLINIC SC
name

112 Helen Street
street address

Sauk City, WI 53583 ph:608-643-3351
city / state / zip fx: 608-643-8162

③ Purpose of disclosure: ☐ Further medical care ☐ Application for insurance ☐ Legal Investigation ☐ Self (personal use)
☐ Other (specify purpose) _____

④ Describe the type of information to be used or disclosed . Records from the time period: _____ to _____

Information requested: ☐ All records (or specify) ☐ Clinic visit notes ☐ Lab reports ☐ Consultations ☐ Immunization records
☐ Allergy Records ☐ Radiology Reports ☐ EKG reports ☐ Other (specify) _____

⑤ In compliance with WI Statutes, the following information will not be released unless box is checked:

☐ Mental health ☐ Alcohol &/or Drug abuse ☐ Developmental disability ☐ HIV test results.

⑥ Unless otherwise revoked, this authorization will expire:

☐ One year from the date authorization is signed. ☐ On the following date, event or condition_____.

⑦ Format for records: ☐ Paper ☐ DVD ☐ Other _____ (Note: If format is not selected, records will be released in paper format.)

Patient Rights

- I understand that I have the right to inspect or copy the information used or disclosed in the authorization.
- I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization upon request.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may no longer be protected by confidentiality rules.
- I understand Prairie Clinic SC may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Prairie Clinic SC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that Federal Privacy Rules dictate circumstances when my health information may be released without my consent .
- If I have questions or need assistance with any of the patient rights listed, I can contact Prairie Clinic's Privacy Officer at (608) 643-3351.

Copying fees: If you are requesting release of information to other medical facilities for further medical care, the records will be provided free of charge. You must pay for copies you request for purposes other than medical care or if requested on DVD.

⑧

_____
Signature of patient or representative

⑨

_____
Date signed

If signed by person other than patient, state reason and authority to do so. Patient is ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased ☐ Health Care Agent
☐ Personal Representative /Domestic Partner of Deceased ☐ Other _____

Rev (10/2012)
FOR OFFICE USE ONLY: Received on _____ by _____. Processed on _____ by _____.

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