



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Aspirus Hospitals

Patient Name _____ Previous last name(s) _____
Date of Birth _____ Phone # _____
Address _____
City, State, Zip Code _____

I authorize the use and/or disclosure of my protected health information:

FROM:

TO:

Name _____
Organization _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Name _____
Organization _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Information to be disclosed includes (please initial):

_____ Discharge Summary _____ Lab Reports _____ X-ray Films _____ Other _____
_____ History & Physical _____ Emergency Record _____ Verbal Exchange _____
_____ Operative/Pathology Report _____ X-ray Reports _____

Dates of Service: _____

In compliance with Michigan and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (please initial):

_____ Mental Health _____ Developmental Disabilities _____ Alcohol &/or Drug Abuse _____ HIV test results

Dates of Service (Specify): _____

Purpose for disclosure:

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Changing Physicians/
Providers | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Legal | | <input type="checkbox"/> Law Enforcement | _____ |

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand that I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event: _____.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Signature of Patient

Date

Signature of Parent/Legal Representative/Relationship

Date