

Original: Medical Record

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Date of Blinh Daytime Phone Previous Name(s)	Name	Address		City	State	Zip
Name of Health Care Provider Plan Other	Date of Birth		Daytime Phone		Previous Nam	e(s)
DiscLOSE TO: Self, Delivery Options: Pick up Mail to address above View on-site Electronic Format Fine cental laddress is shared with another person or the e-mail password is known to others, consider other methods of delivery. HSHS automatically send c-mail through encrypted-scarred means unless otherwise directed. Unencrypted email possessome level of risk, e.g. party could see the information without consent. HSHS is not repossible for unauthorized access to unencrypted containing confident information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving viewing confidential information mencrypted electronic format or s-mail. By selecting the unencrypted e-mail option Tacknowledge the risks have been communicated and accept those risks. Unencrypted Email To be picked up by, I hereby authorize to pick up my records. (Photo ID required.) Send To: Name of Health Care Provider/Flan Other To person of the provider of the provi	JTHORIZES:					
DISCLOSE TO: Self, Delivery Options: Pick up Mail to address above View on-site Electronic Format F- mail 10: If the -email address is shared with another person or the e-mail password is known to others, consider other methods of delivery. HSHS automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted e-mail poses some level of risk, e.g., a party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information unencrypted electronic format or - email. By selecting the unencrypted e-mail option I acknowledge the risks have becommunicated an accept these risks. D Unencrypted Elmail To be picked up by, I hereby authorize	Name of Health Care Provide	ler/Plan/Other				
F. mail to:	Address				Fax # of Healt	h Care Provider
If the e-email address is shared with another person or the e-mail passoord is known to others, consider other methods of delivery. ISINE automatically send e-mail through encrypted secured means unless otherwise directed. Unencrypted email posses some level of risk, e.g., a party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted email containing confidinformation or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing deficial information unencrypted electronic format or e-mail. By selecting the unencrypted e-mail option I acknowledge the risks have been communicated an accept these risks. □ Unencrypted Email To be picked up by, I hereby authorize	DISCLOSE TO:	Self, Delivery Options	: □ Pick up □ Mail to	address above [☐ View on-site ☐ E	Electronic Format
Send To:	If the e-email address automatically send e party could see the in information or any runencrypted electron	is is shared with another -mail through encrypted, information without consists (e.g., virus) potential ic format or e-mail. By	/secured means unless otherw ent. HSHS is not responsible to ly introduced to the computer/	ise directed. Unenco for unauthorized according whe	rypted email poses some cess to unencrypted emain en receiving/viewing con	e level of risk, e.g., a iil containing confidential information
Name of Health Care Provider/Plan/Other	☐ To be picked up by,	I hereby authorize		to pick	up my records. (Phot	o ID required.)
Address	Send To: □					
TE(S) OF INFORMATION TO BE DISCLOSED: From	Name of H	Iealth Care Provider/Plan/O	ther			<u> </u>
(A) years will be disclosed. (Month/Year) Note: Future dates will not be honored. **PORMATION TO BE DISCLOSED:** Abstract of record/Pertinent records	Address				Fax # of Healt	h Care Provider
Abstract of record/Pertinent records History & physical Discharge summary Emergency Department report Consultation reports Operative reports Radiology/Imaging reports Laboratory/Pathology EKG Radiology/Imaging films/CD Progress notes Billing records Billing records and/or information as follows: IDO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws): Alachohol/Drug Abuse HIV Test Results Mental Health/Developmental Disabilities PIRATION: This Authorization is good until the following date/event: Or if this item is left blank, the authorization will expire in (1) year from the date signed. RPOSE (check all that apply – copy fees may apply): Patient Request Continuing Care Legal Investigation/Action Insurance Eligibility/Benefits Other: UR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: to inspect and/or receive a chealth information; to have information be used and/or disclosed by this Authorization if I agree to sign this Authorization, I will be provided wor of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for not be based upon my decision to sign this Authorization form for such purposes but I may be responsible for particle bill for such services; I may revoke this Authorization may be needed to release information to payers for certain menta					_	formation from the
Abstract of record/Pertinent records	=		(Month/Year) (Mont	h/Year) Note: Future	dates will not be honored.	
Emergency Department report			□ III	□ D:1		
Radiology/Imaging reports						
Radiology/Imaging films/CD						
IDO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws): Alcohol/Drug Abuse						
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□ Alcohol/Drug Abuse □ HIV Test Results □ Mental Health/Developmental Disabilities □ Cori ft this item is left blank, the authorization will expire in (1) year from the date signed. RPOSE (check all that apply – copy fees may apply): □ Patient Request □ Continuing Care □ Legal Investigation/Action □ Insurance Eligibility/Benefits □ Other: □ UR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: to inspect and/or receive a chealth information; to have information be used and/or disclosed by this Authorization; if I agree to sign this Authorization, I will be provided by of it: I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for not be based upon my decision to sign this Authorization may be needed to release information to payers for certain mental head ices, AODA services and/or HIV testing, however, I can refuse to sign this Authorization form for such purposes but I may be responsible for pentire bill for such services; I may revoke this Authorization at any time by notifying the authorizing provider's health information department, are, in writing and will not be effective as to uses and/or disclosures already made in reliance upon this Authorization, needed for an insurer to compolicy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to third party prided in this Authorization after having provided treatment in reliance upon this Authorization used and/or disclosed pursuant to norization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal privacy law, Wisconsin or Illineral Regulation (42 CRF, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or a revised permitted by regulations. However, I understand that any disclosure of information used and/or unauthorized re-disclosure a remain may not be protect	Specific records and/or	information as follow	/S			
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