Photo ID Required

125 Hospital Drive
Watertown, WI 53098
920-262-4210
Health Information Fax: 920-390-7959
Health Information Ph: 920-262-4370

_____
Medical Record #

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

PATIENT'S NAME: _____ BIRTH DATE: _____PHONE NO: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NAME OF PROVIDER OR ORGANIZATION RELEASING MEDICAL RECORD INFORMATION:

Watertown Regional Medical Center ☐ Hospital ☐ Clinic ☐ Both Provider Name (if applicable) _____

PERSON OR ORGANIZATION TO RECEIVE THE MEDICAL RECORD INFORMATION (IF OTHER THAN PATIENT):

NAME: _____ ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: _____ RECORD TRANSPORT: ☐ Pick up ☐ Mail ☐ Fax (for urgent requests only) _____

INFORMATION TO BE USED AND/OR DISCLOSED: DATE(S):_____

- ☐ HISTORY & PHYSICAL
- ☐ DISCHARGE SUMMARY
- ☐ OPERATIVE REPORT
- ☐ EMERGENCY RECORD
- ☐ CONSULTATION
- ☐ RADIOLOGY REPORTS
- ☐ LABORATORY REPORTS
- ☐ HIV RESULTS
- ☐ REHAB REPORTS
- ☐ EKG
- ☐ PULMONARY FUNCTION
- ☐ STRESS TEST
- ☐ OTHER:_____
  _____
  _____
  _____

THE PURPOSE OR NEED FOR DISCLOSURE IS:

- ☐ FURTHER MEDICAL CARE
- ☐ APPLICATION FOR INSURANCE
- ☐ DISABILITY DETERMINATION
- ☐ LEGAL INVESTIGATION
- ☐ PAYMENT OF INSURANCE CLAIM
- ☐ VOCATIONAL REHABILITATION EVALUATION
- ☐ OTHER (SPECIFY): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to receive a copy of this authorization-I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to refuse to sign this authorization-**I understand that I am under no obligation to sign this form and that Watertown Regional Medical Center (WRMC) may not condition treatment or payment on my decision to sign this authorization. **Right to withdraw this authorization-**I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the WRMC Privacy Office by contacting 920-262-4279. . I am aware that my withdrawal will not be effective until received by the WRMC Privacy Office and will not be effective regarding the uses and/or disclosures of my health information that WRMC has made prior to the receipt of my withdrawal statement. **Right to inspect and/ or copy my health information to be used and/or disclosed-**I understand that I have the right to inspect and/or receive a copy of the information to be released and that I will be charged a fee for any copies of the medical records that I receive. I authorize the use and/or disclosure of my protected health information as described above. I understand that the information to be released may include information pertaining to the diagnosis and/or treatment of mental illness, alcoholism, drug dependence, a developmental disability, or HIV test results. **Redisclosure notice-**I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. This authorization is to remain in effect for six months from the date of signature, unless otherwise stated. A copy of this authorization shall be as valid as the original.

_____ _____ OR _____
DATE PATIENT'S SIGNATURE SIGNATURE OF PERSON LEGALLY AUTHORIZED TO SIGN FOR THE PATIENT

CHECK APPLICABLE AUTHORITY *(ANY PERSON SIGNING FOR THE PATIENT MUST SPECIFY AND BE ABLE TO PROVIDE PROOF OF THEIR LEGAL AUTHORITY).*

- ☐ POWER OF ATTORNEY
- ☐ COURT APPOINTED LEGAL GUARDIAN
- ☐ PARENT OF MINOR
- ☐ SPOUSE OF DECEASED PATIENT
- ☐ NO SPOUSE SURVIVES; I AM AN ADULT OF THE DECEASED PATIENT'S IMMEDIATE FAMILY.

This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. (To specify an additional time period, please NOTE that if you specify an additional time period this authorization will apply to your medical information generated during the additional time period.)

Other specific expiration date or event (specify): _____(mm/dd/yy)

CHECK REASON WHY PATIENT CANNOT SIGN:

- ☐ MINOR ☐ INCOMPETENT ☐ DISABLED ☐ DECEASED
- ☐ OTHER (SPECIFY):_____

NOTE TO RECIPIENT OF MEDICAL INFORMATION: The confidential information is not to be released to other sources without again seeking the permission of the patient.
NOTE TO RECIPIENT OF DRUG AND ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.

ROI

Staff initials_____