PRIMARY CARE ASSOCIATES of Appleton, LTD

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Previous Names | Birth Date/Medical Record Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED:

	Date of Service		Date of Service
☐ Info Necessary for Cont. Care	_____	☐ Discharge Summary	_____
☐ History and Physical	_____	☐ Operative/Procedure Report	_____
☐ Pathology Report	_____	☐ Consultations	_____
☐ Labs	_____	☐ X-rays	_____
☐ EKG/EMG/EEG	_____	☐ PT/SP/OT	_____
☐ ER/UC	_____	☐ Progress Notes	_____
☐ Immunizations	_____	☐ Other _____	

(Contact Radiology Department to obtain films)

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol Abuse or Test Results
☐ Drug Abuse or Test Results
☐ Mental Health
☐ Developmental Disabilities
☐ HIV Test Results, AIDS or AIDS-Related Disease
☐ Sexually Transmitted Disease
☐ Other _____

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

☐ Further Medical Care
☐ Relocation/Moving
☐ Insurance Change
☐ At the Request of an Individual
☐ Changing Physicians (explain) _____
_____
☐ Workers Compensation
☐ Attorney/Court Case
☐ Insurance
☐ Other (comments) _____
_____
_____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal Privacy Standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that 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 Medical Records Dept. Team Leader. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization -** I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

☐ Parent ☐ Guardian ☐ POA for Healthcare ☐ Spouse/Adult Family Member of Deceased Patient