Edgerton Hospital
Edgerton Hospital Milton Clinic
Edgerton Hospital Fulton Square Clinic
Edgerton Hospital Whitewater Clinic
Edgerton Hospital Quick Care

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

_____ _____ (_____)_____
First, MI, Last Name of Patient (Previous names) Birth Date Phone number

_____ _____
Street Address City, State, Zip

AUTHORIZES:

_____
Individual(s)/agency/organization **making disclosure**

_____
Street Address

_____
City, State, Zip Code

_____
Fax

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

_____
Individual/agency/organization **receiving information**

_____
Street Address

_____
City, State, Zip Code

_____
Fax

INFORMATION TO BE USED OR DISCLOSED:
❑ Progress Notes ❑ Visit/Procedure Report ❑ History & Physical Exam ❑ Discharge Summary
❑ Evaluation/Assessment ❑ Treatment Plan ❑ Education Issues/Needs ❑ Lab Reports ❑ Imaging Reports
❑ Complete Chart ❑ Medical Images ❑ Billing Records ❑ Immunization Records* ❑ Verbal Report
❑ Specific information related to:_____

Please specify further *(if needed)*: _____
**Immunization records can be obtained through the Wisconsin Immunization Registry*

PURSUANT TO WISCONSIN LAW REQUIREMENTS, I SPECIFICALLY REQUEST THE DISCLOSURE OF THE FOLLOWING RECORDS±:
[Check all that apply]
❑ Mental Health ❑ Developmental Disabilities ❑ Alcohol and Other Drug Abuse ❑ HIV test results
❑ Other (Specify):_____

±NOTE TO RELEASE RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal Regulations (42 CFR - Part II) and Wisconsin Statutes 51.30 and 51.61 prohibit you from making any further disclosure of it 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 or other information is NOT SUFFICIENT for this purpose.**

FOR DATES OF SERVICE: From:_____/_____/_____To:_____/_____/_____
MM DD YYYY MM DD YYYY

(If no end date is entered, this authorization will continue to apply through expiration date on page 2).

THE RECORD(S) DEFINED FOR RELEASE INCLUDE RECORD(S) GENERATED AT ALL EDGERTON HOSPITAL AND HEALTH SERVICES LOCATIONS.

PURPOSE OF DISCLOSURE: (Check applicable categories)
❑ Coordinating Care ❑ Insurance Eligibility/Benefits ❑ Claims Resolution ❑ Personal Use ❑ Legal Investigation
❑ Further Medical Care [necessary for Alcohol &/or Drug Abuse per 42 CFR s. 2.2]
❑ Other (Specify):_____

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that I have a right to 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 Edgerton Hospital and Health Services may not condition treatment or payment based on my decision to sign this authorization except regarding: a) research-related treatment, or b) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.
Note--WI law requires the patient's authorization to disclose HIV Records for payment purposes.

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 Edgerton Hospital and Health Services HIM Office at the contact below. I am aware that my withdrawal will not be effective until received by Edgerton Hospital and Health Services and will not be effective regarding the uses and/or disclosures of my health information that Edgerton Hospital and Health Services has made prior to receipt of my withdrawal statement.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 Edgerton Hospital and Health Services HIM Office at the contact below.

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.

EXPIRATION DATE:
This authorization will expire at midnight one year form the date of my signature unless otherwise designated. Other expiration date or event: _____.

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

SIGNATURE:_____**DATE**:_____

If this Authorization is signed by a representative on behalf of the patient, complete the following:
Representative's Name:_ _____

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Health Care Agent_____
❑ Spouse of Deceased ❑ Personal Representative/Domestic Partner of Deceased

EDGERTON HOSPITAL AND HEALTH SERVICES HIM OFFICE CONTACT:

Edgerton Hospital and Health Services
ATTN: HIM
11101 N. Sherman Rd.
Edgerton, WI 53534
Phone: 608-884-1628
Fax: 608-884-1626