



1515 Park Avenue • Columbus, WI 53925
 Phone (920) 623-1528 Fax (920) 623-1581
 Toll Free (800) 549-7511

For CCH use only

Patient's MRN _____ Account # _____ Request Completed/Fulfilled by: _____ Date: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

 Name of Patient/Previous Names

 Birth Date Phone Number

 Street Address

 City, State, Zip Code

AUTHORIZES:

Columbus Community Hospital

TO RELEASE PROTECTED HEALTH INFORMATION TO:

1515 Park Ave

 Name of Health Care Provider/Plan/Individual/Other

Columbus, WI 53925

 Street Address

 City, State, Zip Code

INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records including reports | |
| <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Consultations | <input type="checkbox"/> View Only Access |
| <input type="checkbox"/> Other (Specify): _____ | | |

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- | | | |
|---|--|--|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Personal | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Legal Investigation or Action | |
| <input type="checkbox"/> Other (Specify): _____ | | |

Account # _____ MRN _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

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

Mental Health Developmental Disabilities Alcoholism
 HIV/AIDS Sexually Transmitted Disease Drug Abuse
 Other (Specify): _____

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 receive a copy of 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 Department.

Right to Receive Copy of This Authorization – I agree that if I sign this authorization, which I am not required to do, I will be provided with a signed copy of the form at my request.

Right to Refuse to Sign This Authorization – I understand that 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.

Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw or to receive a copy of my withdrawal, I may contact the Medical Records Department. 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.

HIV Test Results: I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLASURE 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 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. I also understand that there may be a copy fee (s) associated with my request.

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

DATE: _____ **WITNESS:** _____

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Custodial Parent, Legal Guardian, Executor or Estate of Deceased,
Power of Attorney for Healthcare, Authorized Legal Representative