



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

Patient's MRN
Request Completed 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

Name of Health Care Provider/Plan/Other
1515 Park Ave
Street Address
Columbus, WI 53925
City, State, Zip Code

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other
Street Address
City, State, Zip Code

INFORMATION TO BE RELEASED:

- Medical History, Examination, Reports
Treatment or Tests
X-ray Reports
Prescriptions
Other (Specify):
Surgical Reports
Hospital Records Including Reports
Allergy Records
Consultations
Immunizations
Laboratory Reports

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- Continuing Care
Insurance Eligibility/Benefits
Other (Specify):
Personal
Legal Investigation or Action
Changing Physicians

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): \_\_\_\_\_

For the Following Date(s): \_\_\_\_\_

**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.

**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:** \_\_\_\_\_  
(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