Wisconsin Institute of Urology

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original.

PATIENT

_____ _____

Patient Name/ Previous Names associated with Patient | Date of Birth or Medical Record Number

_____ _____

Street Address | City /State/Zip Code

AUTHORIZES:

INFORMATION TO BE RELEASED FROM:

_____

Name of Health Care Provider/Plan/Other

_____

Street Address

_____

City/State/Zip Code

INFORMATION RELEASED TO:

_____

Name of Receiver

_____

Street Address

_____

City/State/Zip Code

_____

Fax Number

INFORMATION TO BE RELEASED INCLUDES:

____History& Physical
____Discharge Summary
____Consultations
____Operative Reports
____Doctors progress notes: dates/type_____
____Other: _____

____ER reports: (dates/type)_____
____X-ray reports (dates/type)_____
____Lab Reports (dates/type)_____

*** Please note x-ray films and pathology slides are not kept at Wisconsin Institute of Urology**

NEED FOR THE DISCLOSURE:

____Changing Physicians/Relocation/Moving
____Disability Determination
____Legal Investigation
____Payment Process /Insurance/Billing difficulties
____Other: _____

____Vocational Rehab Evaluation
____Court Case

____Consultation/Further Medical Care
____Worker's Comp Injury
____Personal
____Application for Insurance

I understand that if the person(s) and/or organization 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 re-disclosed without obtaining my authorization.

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 health information department. **Right to Receive Copy of this Authorization—**I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. **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 that 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 health information 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 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 OF PATIENT/LEGAL REPRESENTATATIVE: _____

DATE: _____ **(**If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: _____ (Employee) Date: _____ Records Released: _____