Reedsburg
AREA MEDICAL CENTER
Organization Focused

2000 N. Dewey Avenue
Reedsburg, WI 53959
(608) 524-6487 ext 1800
(608) 524-2104 FAX

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name *(First, Middle, Last)*	**Previous/Maiden Name**	**Birth Date (Month DD, YYYY)**	**MRN**
Mailing Address of Patient - Street			
City	**State**	**ZIP Code**	**Phone**

Instructions: if **any** section is incomplete, this form may be invalid and the request cannot be processed.

AUTHORIZES REEDSBURG AREA MEDICAL CENTER TO *RELEASE TO*: (Includes Physician Group and Specialty Group)	AUTHORIZES REEDSBURG AREA MEDICAL CENTER TO *OBTAIN FROM*: **(Includes Physician Group and Specialty Group)**
Name of Health Care Provider/Other	Name of Health Care Provider/Other
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Disability Determination ☐ Payment of Insurance Claim

☐ Other_____

Information to be Released

Service Dates (approximate)	☐ Copies ☐ Verbal Exchange of Information (No copies) ☐ Review of my Medical Record

☐ History and Physical	☐ EKG's	☐ Laboratory "Reports	☐ Hospital Notes	☐ ER Report
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Hospital Discharge Summary	☐ Consultation
☐ Clinic Notes	☐ Operative Reports	☐ Radiology Images	☐ Billing Statements	

☐ Other_____

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics.

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. I may be charged for copies in accordance with state law. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Spouse/Adult Family Member of Deceased Patient ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(required)*	**Date Signed** *(required) (Month DD, YYYY)*
Printed Name of Person Signing (if not patient)	

☐ **Copies given to patient/representative at time of service**

FOR ORGANIZATIONAL USE					
Dt Rec'd	**Dt Disclosed**	**Processed By**	☐ **Mailed**	☐ **Faxed**	☐ **Picked Up By**

HYPERLINKS TO: 1) Medical Record Review During Hospitalization Protocol—Patient Focused Manual—(RI);
2) Release/Disclosure of PHI Protocol—Org Focused Manual—(IM)
APPROVAL: 04/03 **REVIEWED:** 2/06 5/06 3/08 **REVISED:** 01/14
DISTRIBUTION: 1) Organization Focused Manual—Management of Information (IM); **2)** Cross-indexed in HIS Department Manual TOC;
3) ES Manual—(PC) part of the "Sexual Assault Evaluation & Treatment Form"; **4) Stock at:** MCC & Business Office
/Authorization for Disclosure of PHI/