

**Authorization to Use or Disclose Protected Health Information (PHI)**

*Law requires written authorization from the patient. All items must be complete to be considered valid.*

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(print) (month day year)

*Check one of the following boxes that applies:*

- I authorize Community Memorial Hospital to disclose my health information to the person or organization named below.  
 I authorize the person or organization named below to disclose my health information to Community Memorial Hospital,  
W180 N8085 Town Hall Road, P.O. Box 408, Menomonee Falls, WI 53052-0408

Name of person or organization: \_\_\_\_\_

Street Address

City/State/Zipcode

State the approximate date(s) of the records from which information is to be disclosed. If you do not know the date(s), write the diagnoses or operation, or exam from those records that you want disclosed: \_\_\_\_\_

Description of Information to be Disclosed. *Check all that apply:*

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> History and Physical  | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Psychological Assessment   |
| <input type="checkbox"/> Consultation          | <input type="checkbox"/> X-Ray Report(s)   | <input type="checkbox"/> CT or MRI Report(s) | <input type="checkbox"/> Psychiatric Evaluation     |
| <input type="checkbox"/> Operative Report(s)   | <input type="checkbox"/> EKG/Echo          | <input type="checkbox"/> Billing Statements  | <input type="checkbox"/> Drug or Alcohol Assessment |
| <input type="checkbox"/> Lab Report(s)         | <input type="checkbox"/> ER Record         | <input type="checkbox"/> Complete Chart      |   |
| <input type="checkbox"/> Other (specify) _____ |  |  |   |

Check the reason as to why this information is to be disclosed:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Further medical care  | <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Payment of insurance claim |
| <input type="checkbox"/> Disability determination  | <input type="checkbox"/> Legal investigation       | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> At the request of the individual ( <i>Note: Check this item when disclosure is being made to the patient.</i> ) |  |   |

I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, HIV test results, or developmental disabilities and genetic testing results, unless I give written instructions not to release such information.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department of the facility I had authorized to make the disclosure. I understand that the revocation will not apply to information that has already been disclosed in reliance of this authorization.

I understand that I have a right to inspect and/or receive a copy of the health information to be released and that I will be charged a fee for any copies of the medical records that I receive.

This authorization is effective until \_\_\_\_\_ (if no date is entered this authorization will remain in effect for 1 year from date of signature), and covers records that were created on or before the date this authorization was signed. It also covers records that are created after this authorization was signed unless the "no" box is checked and initialed.  No. \_\_\_\_\_ Initials.

I understand that if the person or organization that receives my information is not a health care provider or entity subject to the federal privacy rules, the information being disclosed may be re-disclosed and no longer protected by those rules.

I understand that I may refuse to sign this authorization and that Community Memorial Hospital or the other organization or person named above, whom I am authorizing to disclose my protected health information, may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care services to me is solely for the purpose of creating protected health information for disclosure to a third party.

\_\_\_\_\_  
Date Patient's Signature OR Signature of person legally authorized to sign for the patient

Any person signing for the patient must specify their legal authority to sign for the patient and must be able to provide proof of their legal authority.

*Please complete. Check applicable authority:*

- \_\_\_\_ Court appointed legal guardian      \_\_\_\_ Parent of minor      \_\_\_\_ Spouse of deceased patient  
\_\_\_\_ Adult member of the deceased patient's immediate family and patient's spouse is deceased or patient was not married.  
\_\_\_\_ Health Care Agent (patient is incapacitated, as determined in writing by two physicians or a physician and a psychologist)

Original – Medical Record