

1. I HEREBY AUTHORIZE:

2. TO:

- Release information to:
- Obtain information from:
- Exchange information with:

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

3. INFORMATION REGARDING:

\_\_\_\_\_  
(Print first and last name)

\_\_\_\_\_  
(Date of birth)

\_\_\_\_\_  
(Indicate maiden name or previous names used)

4. PURPOSE OR NEED OF DISCLOSURE: (Check applicable categories)

- |  |   |
|--|---|
| <input type="checkbox"/> Further Medical Care                | <input type="checkbox"/> Social Security Disability           |
| <input type="checkbox"/> Application for insurance           | <input type="checkbox"/> Legal Investigation or Action        |
| <input type="checkbox"/> Obtain payment for insurance claims | <input type="checkbox"/> Vocational Rehabilitation Evaluation |
| <input type="checkbox"/> Patient's request (Personal Use)    | <input type="checkbox"/> Other (Specify): _____               |

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.

5. TYPE OF INFORMATION TO BE DISCLOSED: (complete a through c)

- a. Records regarding treatment for: \_\_\_\_\_
- b. Records from the time period: \_\_\_\_\_
- c. Specific information requested: (please specify below)
 

<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Cardiac testing	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Consultations	<input type="checkbox"/> Therapy Notes (OT, PT, Speech)
<input type="checkbox"/> X-ray _____ Lab	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Operative/Pathology Reports
<input type="checkbox"/> Other (Specify): _____		

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: \_\_\_\_\_

6. EXPIRATION DATE: This authorization shall be valid for one year unless otherwise stated or revoked through written notice to the Medical Records Department. Alternate date or event if not one year \_\_\_\_\_

**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 Medical Records 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, 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 or payment on my decision to sign this authorization. **Right to Revoke This Authorization** - I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the Medical Records Department. I am aware that my revocation 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.

7. SIGNATURE OF PATIENT: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

8. SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

(If applicable)

If signed by other than patient, state relationship and authority to do so.

Legal Authority: \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Parent of minor \_\_\_\_\_ Next of Kin \_\_\_\_\_ Power of Attorney  
(Attach court action) (Spouse, if living) (Attach POA papers)



02/03

Meriter Hospital  
Madison, Wisconsin

**AUTHORIZATION/CONSENT FOR RELEASE OF  
MEDICAL INFORMATION 611-28 808459**