Patient Name

LAST FIRST MI

Date of Birth

(MM/DD/YYYY)

Medical Record Number

**I Hereby Authorize:**
(Name and address of releasing facility)

**To Release Information to:**
(Individual name, facility/organization and address)

**PURPOSE OF DISCLOSURE:**

- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use
- ☐ Other (specify): _____

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol/drug use)
- ☐ Behavioral Health
- ☐ HIV related information (AIDS related testing)

X _____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE SIGNED (MM/DD/YYYY)

**INFORMATION TO BE RELEASED:**

| | Between the Dates of: | | Between the Dates of: |
|---|---|---|---|
| ☐ Discharge Summary | - | ☐ X-Ray/MRI/CT Reports | - |
| ☐ H&P Exam/Initial Evaluation | - | ☐ Diagnostic Test Reports | - |
| ☐ Consult | - | ☐ Procedure Reports | - |
| ☐ Progress Notes/Provider Notes | - | ☐ Lab Reports/Pathology | - |
| | | ☐ Correspondence | - |

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with Minnesota Statue 144.33 and Wisconsin Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

X _____ _____ _____

SIGNATURE OF PATIENT, PARENT OF MINOR, OR PERSONAL REPRESENTATIVE RELATIONSHIP DATE SIGNED (MM/DD/YYYY)

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**