PATIENT IDENTIFICATION (Please Print)

NAME _____ OTHER NAMES USED _____

ADDRESS _____ BIRTHDATE____/____/____ MED REC# _____

_____ TELEPHONE # _____

PROVIDER (Who has the information you would like released?)

St. Croix Regional Medical Center ☐ Clinic ☐ Other _____

235 State Street ☐ Hospital _____

St. Croix Falls, WI 54024 ☐ Behavioral Health _____

Attn: _____ Attn: _____

REQUESTOR (Who should the information be sent to?)

St. Croix Regional Medical Center ☐ Clinic ☐ Other _____

235 State Street ☐ Hospital _____

St. Croix Falls, WI 54024 ☐ Behavioral Health _____

Attn: _____ Attn: _____

INFORMATION REQUESTED (Please be specific)

☐ Registration Form ☐ Pathology ☐ Clinic Notes _____

☐ History & Physical ☐ Laboratory ☐ Immunizations

☐ Discharge Summary ☐ X-Ray Reports ☐ Other: _____

☐ Emergency Room ☐ X-Ray CD's _____

☐ Operative Room ☐ Physical Therapy _____

MEDICAL CONDITION (Dates, Info Restrictions)

Medical condition, accident or injury: _____

_____

Date(s) of service: _____

Restrictions to information disclosed? ☐ YES ☐ NO

If Yes, specify: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

In compliance with WI statutes, I specifically authorize the release of information relating to:

☐ Substance / Alcohol Abuse ☐ Mental Health Conditions ☐ HIV/AIDS Related Information/Testing

Note to the REQUESTOR: This information has been disclosed to you from records that may be protected by federal and state confidentiality laws. You are prohibited from making any further disclosure of this information.

PURPOSE OF RELEASE

☐ Referral/Coordination of Care/Treatment ☐ Attorney ☐ Dissatisfied With Care ☐ Changing Clinics

☐ Processing Claim for Payment ☐ Moving Out of Area ☐ Other, Explain_____

I give permission to the PROVIDER to release information described above to the REQUESTOR. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the information disclosed to them may not be protected by federal privacy standards, and therefore, my health information may be re-disclosed without obtaining my authorization. I understand that this authorization will take effect on the date signed and will be in effect for 6 months. I understand I can cancel this authorization at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information received before the provider receives my written notice.

I understand I have a right to inspect and/or receive a copy of the health information to be disclosed. I understand I have a right to request a copy of this authorization.

The person(s) 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 form.

Signature of person releasing information _____ Date____/____/____

If not signed by patient - Reason _____ Relationship to Patient _____

ST. CROIX REGIONAL MEDICAL CENTER
235 State Street • St. Croix Falls, WI 54024

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Rev. 9/17 HIS 1

FOR INTERNAL USE ONLY

Date info sent/given: _____

Initials of persons disclosing info _____

Logged in EHR _____