HudsonPhysicians

Authorization for Use and Disclosure of Patient Health Information

Name of Patient _____ Maiden or Previous Name _____ Birthdate _____

Street Address _____ City, State, Zip _____ Phone Number _____

AUTHORIZE FROM:	***RELEASE INFORMATION TO:***
Name of Healthcare Facility _____	Name of Facility/Individual _____
Street Address _____	Street Address _____
City, State, Zip _____	City, State, Zip: _____
Telephone # _____ Fax#	Telephone # _____ Fax#:

METHOD OF DELIVERY: ☐Fax ☐Mail ☐Pick up_____ ☐Email _____
(select only if you want your records by secure email)

FOR THE FOLLOWING DATES:

From _____ to _____ Records Needed by (appointment date) _____

For specific record date(s):_____

INFORMATION TO BE RELEASED: ☐ **Entire Record** OR choose from the following

☐ Provider Notes
☐ Surgical reports
☐ X-ray reports
☐ Xray Imaging CD
describe _____
☐ Medication List
☐ Laboratory Reports
☐ Immunizations
☐ Other (please specify) _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED - (as defined by applicable state and federal law)

☐ Mental health
☐ HIV (AIDS)
☐ Alcoholism
☐ Other (please specify):_____
☐ Developmental disabilities
☐ Sexual Transmitted Diseases
☐ Drug Abuse

PURPOSE OF DISCLOSURE:

☐ Personal Request ☐Transfer of Care ☐ Insurance ☐ Legal
☐ Other: _____

EXPIRATION:

This authorization expires on _____ . If left blank, the authorization will expire in one year from the date of signature.

I understand that Hudson Physicians will not condition my treatment on whether or not I sign this authorization form except (i) if the information to be disclosed will result from treatment for research purposes, Hudson Physicians will not provide the treatment if I am unwilling to sign this form; and (ii) if the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Hudson Physicians will not provide the treatment if I'm unwilling to sign this form. I understand that I have a right to revoke this authorization at any time by submitting a written request to the following address: Hudson Physicians, C/O Health Information, 403 Stageline Road, Hudson, WI 54016. I understand that any revocation will not have an effect on any actions Hudson Physicians took before it received the revocation. I understand that when Hudson discloses information pursuant to this Authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand that I may be charged a fee for the costs of copying records, subject to state law.

_____ _____
Patient or Patient Representative Signature Date

If signed by person other than the patient, complete the following:
Individual is: ☐Minor ☐Legally Incompetent or Incapacitate ☐Deceased
Legal Authority: ☐Parent ☐Legal Guardian ☐Active POA for Health Care