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:	*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#:

FOR THE FOLLOWING DATES:

☐ From _____ to _____

☐ For specific record date(s): _____

INFORMATION TO BE RELEASED:

☐ Entire Record (of releasing facility only)
☐ Medical history, examinations, reports
☐ Surgical reports
☐ X-ray reports
☐ Other (please specify):_____
☐ Treatment or tests
☐ Laboratory Reports
☐ Immunizations
☐ Consultations

In compliance with Wisconsin law which requires special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental health
☐ HIV (AIDS)
☐ Alcoholism
☐ Other (please specify):_____
☐ Developmental disabilities
☐ Sexually transmitted diseases
☐ Drug abuse

PURPOSE OF DISCLOSURE:

☐ My health information is being disclosed at my request or at the request of my personal representative.

☐ For the following purpose: _____

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 the Patient Representative, state authority to act on behalf of patient