Attention: Medical Records, Release of Information
2600 65th Ave.
P.O. Box 218
Osceola, WI 54020
Phone: 715-294-5725
Fax: 715-294-2874

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION
(Who is the individual whose information you want released?)

Name: _____ Maiden or Previous Name: _____

Birth Date: _____ Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

CLINIC/HOSPITAL/ HEALTH CARE PROVIDER
(Who has the information you want released?)

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

RECEIVING PARTY
(Where do you want the information sent? Who may have the information?)

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED
(What do you want sent or released? Check the appropriate box.)

Date Range: From: _____ To: _____

☐ Progress Notes	☐ Discharge Summaries	☐ OB Records	☐ Medications
☐ Physical Therapy	☐ Lab/Pathology Results	☐ Operation Reports	☐ Billing
☐ ER Reports	☐ Radiology Reports	☐ Consultations	
☐ Hospital Admissions	☐ Radiology Films/CD	☐ Rehab	
☐ Hospital Observations	☐ Letters	☐ Other: _____	

SPECIAL CONSENT

If this section is left incomplete, information relating to this material will not be released.

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this section, I am specifically authorizing the release of information relating to:

☐ Substance Abuse (including alcohol/drug abuse) ☐ Mental Health
☐ HIV-related Information (including AIDS related testing) ☐ Psychotherapy Notes

The confidentiality of this record is required under WI Statute §252.12 and §252.15, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature: _____ Date: _____

RELEASE INSTRUCTIONS
(How and When do you want the information?)

Date information is needed: _____ (NOTE: PLEASE ALLOW 5-7 DAYS FOR PROCESSING)
☐ Mail ☐ Fax ☐ Pick up

PURPOSE OF RELEASE
(Why is it needed?)

☐ Continuing care	☐ Insurance payment/claim	☐ Social Security disability determination*
☐ Personal use	☐ Social Security appeal	☐ Litigation/legal*
☐ Transfer of care	☐ Insurance application*	☐ Other: _____

**Fees may be charged in accordance with WI Statute §146.83 and Federal Rule 45 C.F.R. §164.524*

I have read and understand the following:

- This authorization will last for one year from date of signature or for a lesser period if specified here: _____. Initials: _____
- I may revoke this authorization at any time by providing notification in writing to Osceola Medical Center, and it will be effective on the date received except to the extent action has already been taken.
- A copy or faxed copy of this authorization will be treated in the same manner as the original.
- When Osceola Medical Center discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent re-disclosure, and the information may no longer be protected by federal privacy rules.
- By signing this authorization, I agree to allow Osceola Medical Center and all their employees to disclose the following PHI to the above stated person(s) or entity.
- By signing this authorization I agree to all its contents and release Osceola Medical Center from any and all liability resulting from re-disclosure.
- I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

Signature of patient or authorized person
(If authorized person, identify authority and reason below.)

Authorized person
(If authorized person, please print name.)

Date

Authority to sign (attach legal document): ☐ Parent ☐ Guardian ☐ Legal Agent **Reason patient is unable to sign:** ☐ Minor ☐ Deceased ☐ Other: _____

******Photo ID is required to pick up records/films******

Revised 10/2012