Federal law required that this form be filled out <u>completely</u> to be valid.

Authorization to Use or Disclose Protected Health Information

Patient Name:_____________________________________ **Date of Birth:**____________________ **MR#:**___________

1. **I authorize:**

Memorial Medical Center
1615 Maple Lane
Ashland, WI 54806

Other: ____
____
____

2. **I disclose my protected health information to**: ____
(name & full address) ____
____
Fax Number (if applicable):_____________________

3. **Information to be used or disclosed:** Dates of Service:_______________________________________

Entire Record (continuing care only
Registration/Face Sheet
Discharge Summary
History and Physical
Consultations
Emergency Room Reports
Orders
Physicians Progress Notes
Laboratory Results
X-Ray Reports
X-Ray Films
EKG
Operative Report
Pathology Report
Anesthesia Records
Nurses' Notes
Medication List
Other:____________

4. **I specifically authorize the release of information relating to (if applicable):**

Substance Abuse (including alcohol/drug use)
Behavioral Health
HIV Related Information (AIDS Related Testing)

5. **Purpose of Disclosure:**

Continuing Care
Payment of Claim
School
Workers Compensation
Legal
Personal Use
Other (specify): ____

6. **Expiration & Revocation:**
   - This authorization will expire in 6 months.
   - I can revoke this authorization at any time.
   - If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department.
   - The revocation will not apply to information that has already been released in response to this authorization.
   - The revocation will not apply to my insurance company when the law provides any insurer with the right to contest a claim under my policy.

7. **Acknowledgement of Understanding:**
   - Authorizing the disclosure of this health information is voluntary.
   - I can refuse to sign this authorization.
   - I need not sign this form in order to assure treatment.
   - I can inspect or have copied the information to be used or disclosed, as provided by Federal Law.
   - Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal privacy regulations.
   - This authorization is valid for health information created on or before the date of signature.
   - If I have questions about disclosure of my health information, I can contact the Director of Health Information.
   - I can obtain a copy of this authorization.

____ ____
Signature of Patient or Legal Representative **Date**

____ ____
Relationship of Legal Representative to Patient **Signature of Witness**