

**WISCONSIN STATE PUBLIC DEFENDER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

1. Patient Information:

Name: _____ Date of Birth: _____

Any previous names: _____

I authorize the use and/or release of my protected health information as described in the paragraph five (5) below:

2. I Authorize:

Name of person or organization: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____

Fax Number: _____

Email: _____

3. To release protected health information to:

Name of person or organization you want information released to: _____

Street address: _____

City, State, Zip Code: _____

Phone Number: _____

Fax Number: _____

Email: _____

4. Purpose or need for disclosure:

Legal investigation

Vocational Rehabilitation

Patient's Request

OTHER: _____

5. Types of information to be disclosed:

History and Physical Progress

PA, NP, APNP Notes/Dictation

Pathology Report

Summaries Laboratory Records

Physician Progress Notes/Dictation

AODA Diagnosis/Treatment Information

EKG/EMG/EEG

Nurses Notes/Dictation

Social Work Notes/Dictation

Problem List

X-Ray/Medical Imaging

Admission/Discharge Summaries

Immunization

Operative/Procedure Report

OTHER: _____

Emergency Room Records

Consultations

Physical Therapy/Occupational

Mental Health Diagnosis/Treatment

Therapy/Speech Therapy

Information (Psychiatric & Psychological)

6. Records are requested for the following dates: _____ to _____

This authorization may include disclosure of information regarding mental health/mental illness, developmental disabilities, alcohol and other drug treatment, AIDS or AIDS-related illness, and/or HIV test results unless specified as follows:

The records do not need to be certified unless specified as follows:

7. Expiration Date: This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. To specify an additional time period, please check one of the boxes below. If you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.

Other specific expiration date:

Other expiration event (specify):

8. Disclosure may be in the form of:

Photocopies

Fax

Inspection

CD/DVD

Verbal Disclosure

Email:

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to inspect or copy the health information to be used or disclosed--I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the medical records department. Right to receive a copy of this authorization -- I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form. Re-release--I understand that the protected health information, once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA, and therefore, may no longer be protected by HIPAA. Right to refuse to sign this authorization--I understand that I am under no obligation to sign this form and that the person(s) and/or organizations listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. Right to revoke this authorization--I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the medical records department. I am aware that my revocation will not be effective as to use and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above. I intend that a photocopy of this authorization shall be as effective as the original.

9. Signature of Patient:

Date signed:

10. Person Authorized by Patient (if applicable):

Date signed:

If signed by other than the patient, state relationship and authority to do so:

Legal Authority:

Attorney

Legal Guardian

Parent of Minor

Spouse of Deceased

Power of Attorney

OTHER:

**NOTE TO RELEASING ORGANIZATION/PERSON:
IF THE TOTAL COST OF THIS REQUEST IS OVER \$50,
PLEASE CONTACT THE REQUESTOR PRIOR TO RELEASING THE RECORDS.**