

MILE BLUFF MEDICAL CENTER
Mauston, Wisconsin 53948
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

 Name of Patient/Previous Names

 Birth Date/Medical Record Number

 Street Address

 City, State, Zip Code

AUTHORIZES DISCLOSURE BY:

DISCLOSURE OF HEALTH INFORMATION TO:

 Individual(s)/agency/organization making disclosure

 Individual(s)/agency/organization receiving information

 Street Address

 Street Address

 City, State, Zip Code

 City, State, Zip Code

INFORMATION TO BE USED & DISCLOSED:

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Report-Films | <input type="checkbox"/> Rehab Notes | _____ |
| <input type="checkbox"/> ER Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Consultation | _____ |

For the Following Date(s): From _____ To _____.

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure.*

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Insurance/Claim Purpose | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Relocation/Moving | <input type="checkbox"/> Other _____ |

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 (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or obtain copies of my health information by contacting the Health Information Dept. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that MBMC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Exception: To provide care that is done solely for the purpose of creating PHI for release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). **Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Health Information Dept. I am aware that my withdrawal will not be effective until received by MBMC and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP.: _____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so)

DISCLOSURES REQUIRING SPECIAL CONSENT: My signature below specifically authorizes the release of health information relating to the Testing, diagnosis, and treatment for:

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mental/Behavioral Health Conditions | <input type="checkbox"/> Drug/Alcohol Abuse/Treatment |
|-----------------------------------|--|---|

SIGNATURE PATIENT/LEGAL REP.: _____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so).

FOR ORGANIZATION'S USE				
Date Received:	Date & Time Released:	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed	<input type="checkbox"/> Picked Up By: