

Black River Memorial Hospital

711 W Adams St.
Black River Falls, WI 54615
(715)284-5361 FAX (715)284-7166

Reference Number

Medical Record Number

Admission Number

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (Complete in full)

1. _____
(Name of Patient) (Previous/Maiden Name) (Birthdate)

I authorize the use or disclosure of the above-named individuals health information as described below. I understand that I have the right to refuse to sign this authorization.

<p>2. The following individual or organization is authorized to make the disclosure:</p> <p>_____ (Name of Organization releasing the Info)</p> <p>_____ (Street Address)</p> <p>_____ (City, State, Zip Code)</p>	<p>3. The following individual or organization is authorized to receive the disclosure: [] via fax [] via mail [] other</p> <p>_____ (Name of Organization releasing the Info)</p> <p>_____ (Street Address)</p> <p>_____ (City, State, Zip Code)</p>
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4. INFORMATION TO BE RELEASED:

- Records pertaining to inpatient/outpatient treatment _____ approximate date(s) or condition
- Photograph(s) _____
- Health care information related to mental health, alcohol or drug abuse, or a developmental disability.
- HIV Test results according to Wis. Stat. 252.15, I have the right to request a list of releases made of my HIV test results without my consent.

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

- Further medical care
- Payment of insurance claim
- Legal investigation
- Application for insurance
- Vocational rehabilitation evaluation
- Personal
- Disability determination
- Other _____

Right to Inspect or Copy the Information to be Used or Disclosed

I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Black River Memorial Hospital's Privacy Officer.

Right to Receive a Copy of this Authorization

I understand that if I agree to sign this authorization, which I am not required to do, I may receive a copy of this signed authorization.

Redisclosure of Information by Recipient

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Black River Memorial Hospital's Privacy Officer at 711 West Adams Street, Black River Falls, WI 54615 (715)284-5361.

