

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 <b>make the disclosure</b>:</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 <b>receive the disclosure</b>: <input type="checkbox"/> via fax <input type="checkbox"/> via mail <input type="checkbox"/> other</p> <p>_____          (Name of Organization receiving 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.

