Black River MEMORIAL HOSPITAL

Medical Record Number

FIN

PATIENT REQUESTED 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 individual's health information as described below. I understand that I have the right to refuse to sign this authorization.

2. The following individual or organization is authorized to **make the disclosure**:	**3.** The following individual or organization is authorized to **receive the disclosure**: [ ] via fax [ ] via mail [ ] other
Black River Memorial Hospital 711 West Adams Street Black River Falls, WI 54615	______________________ (Name of Organization receiving the Info) ______________________ (Street Address) ______________________ (City, State, Zip Code)

4. INFORMATION TO BE RELEASED:

☐ Records pertaining to inpatient/outpatient treatment ______________________
approximate date(s) or condition

☐ Photograph(s) ______________________

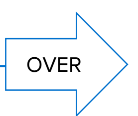
☐ Health care information related to mental health, alcohol or drug abuse, or a developmental disability.

☐ 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.

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.



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____
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(continued)

Prohibition of Conditions

Black River Memorial Hospital may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Black River Memorial Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional period of time.

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6. I understand that if Black River Memorial Hospital uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

7. I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request. (See **Right to Revoke Authorization**.)

A photocopy of this authorization shall be considered as valid as the original.

Employee Initiating Form: ______________________________ Date/Time:__________________

☐ **By checking this box I (the patient) am <u>requesting a copy</u> of this authorization.**

☐ Copy of Authorization given

8. Signature of patient: ________________________________ Date/Time: __________________

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

9. Witnessed by (if applicable): __________________________ Date/Time: __________________

(If you are signing as a parent of the minor patient listed above, you are declaring that your parental rights have not been terminated and you have not been denied physical placement of the child).

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal Guardian **(Attach proof of court action)** ☐ Parent of Minor

☐ Next of Kin of Deceased **(Immediate family member of deceased)**

Note to recipient of drug and alcohol abuse and HIV information:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to Federal Law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Disclosure is also covered under Wis. Stat. 146.81/146.83 and Wis. Mental Health Act Chapter 51.30

BRMH USE ONLY

Medical Records Released by: __________________________ Date/Time:__________________

Route: ☐ Mail ☐ With Patient ☐ Other: ________________ ☐ Copy of this authorization provided