THIS AUTHORIZATION IS HIPAA COMPLIANT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name:	LAST:	FIRST:	MIDDLE:
Street Address:			
City:		State:	Zip Code:
Medical Record Number (if known)	Birthdate:		Phone No.:

2. Information to be Disclosed. (Please check only one box)

☐ Comprehensive overview of entire chart (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray, EKG and lab reports OR Complete copy of official medical record.

☐ Records pertaining to (e.g. date(s) or condition(s)): _____

☐ To exchange written or verbal information between school and provider

☐ Prescription drug records & Current medication orders

☐ **Other (describe):** _____

3. Disclosed By:

Name - (e.g. Health Facility, Physician …)		
Address	Phone Fax	
City	State	Zip

4. Disclosed To:

Name - (e.g. Insurance Company, Lawyer, Physician, Patient …) Dodgeville School District		
Address 916 W. Chapel St.	Phone 608-935-3307 Fax 608-935-3021	
City Dodgeville	State WI	Zip 53533

5. Purpose or need for disclosure. (Please check all applicable categories)

☐ further medical care
☐ application for insurance
☐ disability determination
☐ payment of insurance claim
☐ vocational rehabilitation
☐ other: _____
☐ legal investigation
☐ patient use

6. 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 <u>one</u> of the boxes below. NOTE that 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: _____ (use month/day/year)
☐ Other expiration event (specify): _____

**** PLEASE SEE REVERSE FOR FURTHER INFORMATION ****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exceptions: _____

Signature of Patient: _____ **Date:** _____

If signed by a person other than patient, state relationship and authority to do so in the space below. (See reverse for additional information about signatures.)

RELATIONSHIP: _____

PATIENT IS: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

LEGAL AUTHORITY: ☐ Health Care Agent _____
☐ Personal Representative of Deceased ☐ Other: _____

Release Documentation

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Patients have a right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authority.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, health care providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to the provider listed on the front of this form.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the patient accounting or medical records department of the health care provider where you received medical or other care.

Multiple Releases of Information. A patient may request multiple releases of information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future may be released, for example, "future records for a specific test" or "future records of a specific clinic appointment."

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you.

Fees for Records. The provider may charge a reasonable fee for copying and postage to fulfill this request. All fees are based on applicable laws governing release of health information.

Initials: **Please initial that you have read the above paragraphs _____**