VERNON MEMORIAL HEALTHCARE
507 SOUTH MAIN ST., VIROQUA, WI 54665

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT:

_____ _____
Name: Last, First, MI Date of Birth

_____ _____(_____)_____
Street Address City, State, and Zip Phone

DISCLOSURE AUTHORIZED BY:

_____
Name

_____
Street Address

_____
City, State, and Zip

DISCLOSURE OF PHI TO:

_____
Name

_____
Street Address

_____
City, State, and Zip

TYPE OR EXTENT OF PHI TO BE RELEASES: (CHECK ALL APPLICABLE CATEGORIES)

_____Medical history, examination, reports
_____Operation reports
_____Cardiopulmonary diagnostic and rehab reports
_____X-ray reports
_____Hospital records, including nurses' notes
_____Therapy records
_____Laboratory reports
_____Prescriptions
_____Consultations
_____ER reports
_____Other _____

For the following date(s): From:_____ To: _____

In compliance with WI statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

_____HIV test results
_____Alcohol & drug abuse records
_____Psychotherapy notes
_____Sexually transmitted disease reports
_____Mental health records / counseling
_____Social work counseling / therapy
_____Domestic violence counseling
_____Sexual assault counseling

For the following dates: FROM:_____ To: _____

PURPOSE FOR NEED OF DISCLOSURE: Check all applicable categories

_____Further medical care
_____Insurance eligibility/benefits
_____Other _____
_____Coordinating care for dependant/spouse
_____Claims resolution

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of this Authorization - I understand that if I agree to sign this authorization, I must be provided with a copy. **Right to Refuse to Sign this Authorization** - I understand that I am under no obligation to sign this form and that Vernon Memorial Healthcare may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care benefits that is solely for the purpose of creating PHI for disclosure to a third party. ****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 Vernon Memorial Healthcare. This withdrawal will not be effective regarding the uses/disclosures of information that VMH has made prior to receipt of your withdrawal. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***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. ****WI Statutes 51.30 and 252.15** require patient authorization to disclose health information for payment purposes.

REDISCLOSURE NOTICE: Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and would no longer be protected by this authorization. I understand that any disclosure of information carries the potential for an unauthorized redisclosure, especially if the information is no longer protected by Federal or State privacy standards.

Expiration Date: This authorization is good until (indicate date or event) _____.
By signing this authorization I am confirming that it accurately reflects my wishes.

My signature indicates that I have received a copy of this form.

_____ _____

Signature of Patient Date
(If signed by person other than patient, state relationship to patient)

Patient is: _____Minor _____Incompetent _____Deceased
Legal Authority: _____Parent or Legal Guardian _____Next of Kin of Deceased

This release is executed in conformity with State and Federal Privacy Laws.