1050 Division Street | Mauston, Wisconsin 53948
608-847-6161 | milebluff.com

MileBluff MEDICAL CENTER

Healthcare evolving for life

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

_____ Name of patient (list current, and previous names)

_____/_____/_____ Birth date (MM/DD/YYYY)

_____ Medical record number

_____ Street address

_____ City

_____ State

_____ Zip code

(_____) - _____ - _____ Primary phone number

(_____) - _____ - _____ Secondary phone number

_____ E-mail address

REQUESTING HEALTH INFORMATION DISCLOSURE BY:

_____ Individual(s)/agency/organization to send information

_____ Street address

_____ City

_____ State

_____ Zip code

(_____) - _____ - _____ Phone number

(_____) - _____ - _____ Fax number

REQUESTING DISCLOSURE TO:

_____ Individual(s)/agency/organization to receive information

_____ Street address

_____ City

_____ State

_____ Zip code

(_____) - _____ - _____ Phone number

(_____) - _____ - _____ Fax number

INFORMATION TO BE USED & DISCLOSED:

- ☐ Discharge summary
- ☐ Laboratory report
- ☐ Operative report
- ☐ History & physical
- ☐ Radiology report (films)
- ☐ Rehab notes
- ☐ ER report
- ☐ Pathology report
- ☐ Consultation
- ☐ Progress notes
- ☐ Immunization records
- ☐ Electrocardiogram records
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ All clinic records (including any records on file from other facilities)

Disclose records for the following date(s): from _____/_____/_____ (MM/DD/YYYY) to _____/_____/_____ (MM/DD/YYYY)

REASON FOR REQUESTING DISCLOSURE:

- ☐ Further medical care
- ☐ Personal use
- ☐ Insurance/claim
- ☐ Legal investigation
- ☐ Workers' compensation
- ☐ Relocation/moving
- ☐ Disability determination
- ☐ Other:_____

Continue on other side

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be used or disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or obtain copies of my health information by contacting the Health Information Department.

Right to receive copy of this authorization - I understand that if I agree to sign this authorization, I will be provided with a copy of it.

Right to refuse to sign this authorization - I understand that I am under no obligation to sign this form and that Mile Bluff Medical Center may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this authorization (exception: to provide care that is done solely for the purpose of creating protected health information for release to another party, in which case care cannot be provided without authorizing disclosure). Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.

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 the Health Information Department. I am aware that my withdrawal will not be effective until received, and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and/or organization(s) listed here have made prior to receipt of my withdrawal statement. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

HIV test results - I understand my HIV test results may be released without authorization to persons/organizations that have access under State law, and that a list of those persons/organizations is available upon request.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

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I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. (*If you are signing as a parent of the minor patient listed above, you are declaring that you have parental rights and physical placement of the child.)*

SIGNATURE FOR AUTHORIZATION: ____ _____/_____/_______

Signature of patient or legal representative — Date (MM/DD/YYYY)

If signed by someone other than patient, state relationship and authority to do so below:

____

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DISCLOSURES REQUIRING SPECIAL CONSENT: My signature below specifically authorizes the release of health information relating to the testing, diagnosis, and treatment for:

☐ HIV/AIDS ☐ Mental/behavioral health conditions ☐ Drug/alcohol abuse/treatment

SIGNATURE FOR AUTHORIZATION: ____ _____/_____/_______

Signature of patient or legal representative — Date (MM/DD/YYYY)

If signed by someone other than patient, state relationship and authority to do so below:

____

EXPIRATION DATE: This authorization expires one year after the signed date above, unless noted here. _____/_____/_______

Expires (MM/DD/YYYY)

- -

FOR ORGANIZATION USE ONLY				
Date received:	Date & time released:	☐ Mailed	☐ Faxed	☐ Picked up by: