Authorization for Use and Disclosure of Patient Health Information

Name of Patient	Maiden or Previous Name	Birthdate

Street Address	City, State, Zip

AUTHORIZE:		RELEASE RECORDS TO:	
Name of Physician/Healthcare Facility		Name of Physician/Healthcare Facility	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Telephone #	Fax #	Telephone #	Fax #

INFORMATION TO BE RELEASED:

- ☐ Medical history, examination, reports
- ☐ Allergy records
- ☐ Surgical reports
- ☐ Entire record (of releasing facility only)
- ☐ X-ray reports
- ☐ Treatment or tests
- ☐ Consultations
- ☐ Laboratory Reports
- ☐ Immunizations
- ☐ Prescriptions

☐ Other (please specify): ______________________________.

For the following date(s): ______________________________.

In compliance with Wisconsin law, which requires special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental health
- ☐ HIV (AIDS)
- ☐ Alcoholism
- ☐ Genetic Testing
- ☐ Other (please specify): ______________________________.
- ☐ Developmental disabilities
- ☐ Sexually transmitted diseases
- ☐ Drug abuse

For the following date(s): ______________________________.

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The use or disclosure (as applicable) is for the following purpose(s):

- ☐ Further medical care
- ☐ Insurance benefits/eligibility
- ☐ Legal investigation or action
- ☐ Changing physicians
- ☐ Personal reasons
- ☐ Other (please specify): __________

I understand that Vibrant Health Family Clinics will not condition my treatment on whether or not I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, Vibrant Health Family Clinics will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Vibrant Health Family Clinics will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to Vibrant Health Family Clinics HIS Department Supervisor. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that Vibrant Health Family Clinics may have already made in reliance on this authorization. I understand that when Vibrant Health Family Clinics discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I understand that the disclosure of information under this authorization may result in direct or indirect remuneration to Vibrant Health Family Clinics from a third party.

This authorization expires upon the earlier of ________________________ or one year from the date below.

I understand and agree to the terms of this authorization:

____   ___________________________
Patient (or Patient Representative) Signature   Date

____   _________________________
Patient's Date of Birth   Day Time Telephone #

If signed by Patient Representative, state authority to act on behalf of patient:

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OFFICE USE: PHOTO /IDENTIFICATION VERIFIED:
______(DATE) _______________ (STAFF INITIALS)

***IF LEAVING OUR CLINIC – REASON:

_____ DISSATISFACTION _____ MOVING _____ INSURANCE

_____ CONVENIENCE OF HOURS _____ CONVENIENCE OF LOCATION

<u>Clinic Contact Information:</u>

River Falls site	phone# 715-425-6701	fax# 715-425-9420
Ellsworth site	phone# 715-273-5041	fax# 715-273-5271
Spring Valley site	phone# 715-778-5591	fax# 715-778-5024