Lakeview Medical Center

PHONE (715) 236-6275 FAX (715) 236-6573)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This entire authorization must be filled out completely. Please print or type. Read each section and enter all of the needed information. If all areas are not filled out completely and accurately, this authorization will be returned to you requesting the additional needed information. If you have questions on how to fill out this form please call Release of Information Services at Lakeview Medical Center at (715) 236-6275 and you will receive the necessary help.

PATIENT NAME:_____ ADDRESS: _____

PHONE: _____ SSN: _____ DATE OF BIRTH: ____/____/_____ MR#:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

_____**Lakeview Medical Center**_____

Name of Individual or Organization Sending Information

Address__**1700 West Stout Street, Rice Lake, WI, 54868**_____

3. The specific type of information to be used or disclosed is as follows:

Specific Information: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and treatment for alcohol and drug abuse. If contained in the health record this information may be disclosed unless indicated here by initialing on this line _____ and checking the information not to be disclosed. Do not release the following information (check those that apply):

O AIDS or HIV Information O Sexually Transmitted Disease O Behavioral or Mental Services O Drug/Alcohol Abuse

5. This information may be disclosed to and used by the following individual or organization (give complete address including street and number, city, state and ZIP code; if this information is not complete this request will be returned to you):

_____

Name of Individual or Organization Receiving Information

Address_____

6. This information is needed for the purpose of:_____

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____(not to exceed 12 months from date signed). If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date signed.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure of the information and may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Release of Information Services at Lakeview Medical Center at (715) 236-6275.

By signing I acknowledge that I have read, understand and agree with the above. By signing I further understand that I may be charged in accordance with state and federal statutes for the processing of the requested records.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

PLEASE CHECK FOR PAPER COPY REQUEST ☐ **PLEASE CHECK FOR ELECTRONIC REQUEST** ☐

Records Given to Patient (please circle one) Yes No **Records Faxed to Healthcare Facility (please circle one) Yes No**

Sign and date when records were given to patient or faxed

Signature _____ **Date** _____