**GUNDERSEN**
**MOUNDVIEW**
**HOSPITAL AND CLINICS**
**402 West Lake Street, P.O. Box 40**
**Friendship, WIS. 53934**
**Telephone: (608) 339-8375 Fax: (608) 339-4435**

# AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATON

**Name:** _____ **Birthdate:** _____ **Parents Name, if Minor:** _____

**Address:** _____

**I hereby authorize and request: Gundersen Moundview Hospital and Clinics to: (Check one)** ☐ **Release To or** ☐ **Obtain From**

**Name:** _____

**Address:** _____

_____

**Telephone Number:** _____ **Fax Number:** _____

**INFORMATION TO BE DISCLOSED AND DATE OF SERVICE:**

☐ All Clinic Records ☐ Other Facility Records ☐ Discharge Summary
☐ History & Physical ☐ Surgical Report ☐ Lab Reports
☐ X-ray Reports ☐ EKG ☐ Radiology Films

**Other:** _____

**Dates of Service:** _____

**In compliance with Wisconsin statutes which require special permission to release otherwise highly confidential information, please release records pertaining to:** (please check all that apply)

☐ Mental Health ☐ Developmental Disabilities ☐ HIV Test Results
☐ Alcohol & Drug Abuse Other: _____

**PURPOSE:** Please provide specific purpose for disclosure.

☐ Continuing Care ☐ Insurance ☐ Workers Compensation
☐ Personal ☐ Legal Other: _____

**EXPIRATION DATE:** This authorization is good for one year from date signed.

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.

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

_____ _____
**Signature of personal representative, person authorized by the patient or other legal authority** **Relationship/legal authority**

_____ _____ _____
**Request Given to** **Pages to Patient** **Date**

**Continued on back**

## RE-DISCLOSURE OF INFORMATION

I understand that if the person and/or organization listed above are not health care providers, health plans or health care clearinghouse, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

## YOUR RIGHTS REGARDING THIS AUTHORIZATION:

**Right to Receive Copy of This Authorization:**
I understand that if I sign this authorization, I will 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 the covered entity 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 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 Gundersen Moundview Hospital and Clinics. I am aware that my withdrawal will not be effective until received by Gundersen Moundview Hospital and Clinics and will not be effective regarding the uses and/or disclosures of my health information that Gundersen Moundview Hospital and Clinics has made prior to receipt of my withdrawal statement. I understand 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.

**MARKETING:**
I understand if Gundersen Moundview Hospital and Clinics uses the authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use of disclosure of my information.

**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 my health information or obtain copies of my health information by contacting the Health Information Management Department.

**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.