GUNDERSEN
TRI-COUNTY
HOSPITAL AND CLINICS

Information Released by Whom:____________________________

Date/Time Information Released:___________________________

Info Released:____

Authorization For The Disclosure Of Protected Health Information

Patient Information: **Name:** _______________________ **Date of Birth:** __________ **MR#**_____________________

Address: ____

City: ____________________ **State:** ____ **ZIP:** ________ **Phone #** ________________________________

Who will be
___RELEASING
___RECEIVING
The records:

Name: Tri-County Memorial Hospital, Inc.
d/b/a Gundersen Tri-County Hospital and Clinics
Address: 18601 Lincoln Street Whitehall WI 54773
Phone #: 715-538-4361 Fax #: 715-538-2009

OTHER FACILITY: (Name/Address) (Fax/Phone)

Who will be
____RECEIVING
____REQUESTING
____RELEASING
THE RECORDS:

Name/Facility: ____
Address: ____
City: ______________________________ **State:**_________ **Zip:**__________
Phone # ___________________________ **Fax#**____________________________________

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*(*Check all categories that apply. Specify dates or time periods when known.)

Type of information to be released:

_____ Medical history information from __________ to ___________

_____ Lab _____X-rays/EKG/Echo reports

_____ Others: ____

In compliance with state and federal laws, which require special permission to release otherwise privileged information please release records pertaining to:

Mental Health______ Developmental Disabilities_______ Alcohol and Drug Abuse_____ HIV test results________

For the following Dates(s): From_____________________ To _______________________

Purpose or need for disclosure:

_____ Continuation of care ____ Insurance _____ Other:____________________

____ Legal investigation _____ Disability determination ____ Personal

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Delivery Method:

____ Mail _____ Pick up by patient/authorized designee _______ Other

There may be charge/fee for copies of records

By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, the information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material disclosed. **Copies of records may be obtained with reasonable notice and payment of copying costs.**

Signature of Patient: ______________________________ **Date:** ____________________

Signature of Parent, Guardian or Legal Representative: ___________________________ **Date:** _____________

(If not signed by patient, identify relationship to patient. If Legal Guardian/POA provide a copy of authority)
Authorization expires upon release of above requested information.

This authorization may be revoked in writing at any time prior to the disclosure of this information. Federal law prohibits copying or disclosure of information for parties other than those specified.

1/2013