



AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

INSTRUCTIONS: COMPLETE SECTIONS 1 – 5 AS APPLICABLE.

4600 W Schroeder Dr. Brown Deer, WI 53223 414-355-9000
9916 75th St. Kenosha, WI 53142 262-942-4000

11101 W. Lincoln Ave, West Allis, WI 53227 414-327-3000
34700 Valley Road, Oconomowoc, WI 53066 262-646-4411

1. I authorize Rogers Memorial Hospital to: Disclose to Obtain from Med .Rec. #: _____

PATIENT NAME MAIDEN NAME DATE OF BIRTH INDIVIDUAL/AGENCY/ORGANIZATION RECEIVING INFORMATION/RELATIONSHIP TO PATIENT
PATIENT STREET ADDRESS STREET ADDRESS
CITY STATE ZIP CODE CITY STATE ZIP CODE
HOME TELEPHONE WORK TELEPHONE TELEPHONE NUMBER FAX NUMBER

2. I authorize VERBAL exchange of any issues discussed in treatment or documented in my medical record which may include my diagnosis, and/or treatment of alcohol/drug abuse, mental health, developmental disabilities, and/or HIV test results.

3. I authorize WRITTEN documents to be released: Check all that apply.

- Discharge Summary Psychiatric Evaluation Laboratory/Radiology/EKG reports
Personal Recovery Plan Psychological Evaluation HIV results
Medication Reconciliation Educational Planning Information, incl. I.E.P Immunization record
History & Physical Examination Other:

4. For the following treatment date(s) of: This authorization remains in effect for continuous treatment between levels of care or is effective for a time period of ONE YEAR from the date of signature unless otherwise specified. Insert expiration date

5. PURPOSE OF DISCLOSURE: Check all that apply.

- Further care Legal matters Claims resolution
Insurance Eligibility/benefits Personal use Other: (Specify purpose)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive copy of authorization: You understand that if you sign this authorization, you may request a copy of this authorization. Right to refuse to sign this authorization: You understand that you are under no obligation to sign this form and Rogers Memorial Hospital may not condition treatment, payment, or eligibility for health care benefits on your decision to sign this authorization except regarding: a) research-related treatment, b) provision of health care that is solely for the purpose of creating personal health information for disclosure to a third party. Right to cancel this authorization: You understand that you may cancel this authorization at any time by providing a written statement of cancellation to this hospital. You are aware that your cancellation will not be effective until received by this hospital and will not be effective regarding the uses or disclosures of your health information made prior to the receipt of the cancellation statement. Right to inspect or copy the health information to be used or disclosed: You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information department. HIV 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.

NOTICE TO RECIPIENT OF INFORMATION

If the patient is a minor (14 years and older) is receiving treatment for alcohol or drug abuse services as an outpatient, the parents may have access to the treatment records only with the minor's authorization or in accordance with 42 CFR 2.14. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) and HIPAA regulations (45 CFR). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (Sec.2.32).

Patient Signature Date/Time
Parent / Guardian / Legal Representative Signature Relationship to Patient Date/Time
Witness Signature Photocopy/facsimile copy is as valid as the original document. Date/Time