AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

GRANT REGIONAL HEALTH CENTER, INC. and GRANT REGIONAL COMMUNITY CLINIC
507 South Monroe Street, Lancaster, WI 53813
Phone: (608) 723-3265 Fax: (608) 723-3354

Patient:

Name (*First, Middle, Last*)	Birth Date *(Month, DD, YYYY)*	MR#

Street Address	City, State, Zip Code

Release of Information From:

❒ Grant Regional Health Center, 507 S. Monroe St., Lancaster, WI 53813
❒ Other *(Specify facility below)*

Name of Health Care Provider

Street Address

City, State, Zip Code

Phone # Fax #

Release of Information To:

❒ Grant Regional Health Center, 507 S. Monroe St., Lancaster, WI 53813
❒ Patient ❒ Other *(Specify facility below)*

Name of Health Care Provider

Street Address

City, State, Zip Code

Phone # Fax #

Information To Be Released: *(Most recent 2 years, unless otherwise specified)*

❒ ER Record ❒ Radiology reports ❒ Laboratory reports ❒ Operative report ❒ Entire Medical Record
❒ Hospital notes ❒ Radiology images ❒ Discharge Summary ❒ Other *(specify)* _____
❒ Clinic notes

Service Dates: From: _____ To: _____

I specifically authorize use or disclosure of health information pertaining to:

❒ Alcohol and/or Drug Abuse ❒ Mental Health ❒ Development Disabilities ❒ HIV (AIDS)

Purpose of Release:

❒ Continued Care ❒ Transfer of care ❒ Personal ❒ Insurance ❒ Legal Purposes ❒ Disability Determination ❒ Other

I understand that if the person(s) and/or organization(s) listed above may not be health care providers, health plans or health care clearinghouses 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 redisclosed without obtaining my authorization.

Format for Records: ❒ Paper ❒ CD/DVD ❒ Electronic
Please note, if a format is not selected, records will be in paper format

RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect and/or Copy PHI - I understand that I have the right to inspect or copy 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. **Right to Receive Copy of the Authorization** – I understand that if I sign this authorization, I have the right to a signed copy of the form. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health care plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Management Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already taken action in reliance on this authorization. This information is included in the Grant Regional Health Center's Notice of Privacy Practices.

Authorization Expiration Date: This authorization will expire one (1) year from date of signing unless otherwise indicated here:_____

_____ _____
Signature *(Required)* Date Signed *(Required)*

Printed Name of Person Signing ❒ Parent ❒ Legal Guardian (include documentation of relationship)

For Staff Use :

Staff/Dept. Assisting Patient _____
Name Dept. Date Ext #

☐ To HIM for Release of Information Processing ☐ To HIM to Log *(Records Released)*

(A copy of this authorization shall be as valid as the original) 10/23/2018