Southwest HEALTH

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label

Medical Record:_____

HAR:_____

Patient Name:_____

Date of Birth:_____

Address:_____

Phone Number:_____

Send Records From:

☐ **Southwest Health Hospital** 1400 Eastside Rd. Platteville, WI 53818	☐ **Southwest Behavioral Services** 1450 Eastside Rd. Platteville, WI 53818	☐ **Kieler Clinic** 3695 Prism Lane PO Box 263, Kieler, WI 53812
☐ **EMS** 1350 Eastside Rd. Platteville, WI 53818	☐ **Platteville Clinic** 1450 Eastside Rd. Platteville, WI 53818	☐ **The Eye Center** 1450 Eastside Rd. Platteville, WI 53818 or 1509 Ihm St. Lancaster, WI 53813 or 133 Performance Dr. Darlington, WI 53530 or 170 McGregor Plaza, Platteville, WI 53818
☐ **Cuba City Clinic** 2388 Highway 80, Cuba City, WI 53807	☐ **Darlington Clinic** 133 Performance Dr. Darlington, WI 53530	
☐ **Other:**_____ **Name of Organization**	_____ **Address**	_____ **Phone/Fax**

Send Records To: ☐ **Release records to MyChart**

Name:_____

Address:_____

Fax/Pickup:_____

Information to be Released:

Date(s) of treatment and/or specific illness/injury:_____

☐ Emergency Room Report	☐ History & Physical	☐ Discharge Summary	☐ Operative Report
☐ EKG	☐ Consultation	☐ Progress Note(s)	☐ Labs/Pathology
☐ Clinic Only	☐ Radiology Report	☐ Radiology Films/CD	☐ Rehab Therapy Records
☐ Eye Center	☐ SBS *see below	☐ Other: _____	

Purpose of Disclosure:_____

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV Test results

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand this authorization will expire one year from today's date or the date identified: _____, whichever is sooner. Records will only be released up to the date of the signature.
- This authorization may be revoked in writing at any time. A cancellation will not change releases that happen before the cancellation. Southwest Health will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Southwest Health records may include records that it receives from other organizations. If these records have been used by and filed in the record Southwest Health maintains about you, these records may be released with your Southwest Health records.
- Southwest Health cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Southwest Health from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

SIGNATURE PATIENT/LEGAL REP: _____ DATE:___/___/____

(If signed by other than individual, state relationship with signature)