

PATIENT AUTHORIZATION FOR RELEASE & DISCLOSURE  
OF HEALTH INFORMATION

TO:

RE: Patient Name:

Patient Birth Date:

1. I authorize the above-named health care provider (“you”) to release to **[employer or its insurance carrier]**, the above-named patient’s health information, described in paragraphs 2 through 4 below. I understand this authorization is voluntary and is made to confirm my instructions. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization or my signing this authorization. The purpose of this disclosure is at my request. This authorization also permits a representative from **[employer or its insurance carrier]** to personally review all medical information in your possession or control and to orally discuss this information with you. You are NOT authorized to discuss my medical treatment or health information with **[employer or its insurance carrier]**.

2. The health information authorized for release to **[employer or its insurance carrier]** is all medical records in your possession or control, for all dates of service, for all medical conditions and treatment, whether the record was created by you or any other health care provider. “Medical records” includes all documents in my medical chart/record, including correspondence, dictated and handwritten notes, questionnaires, intake documents, lab, radiology and other diagnostic study reports, phone messages, billing and insurance records, and all other documents relating to me.

3. In compliance with Wisconsin law, I also specifically authorize you to release health information relating to the following checked items. You are NOT authorized to release these records unless indicated here:

Mental Health       Developmental Disabilities  
 HIV/AIDS       Alcohol and Drug Abuse Evaluation/Treatment

4. You are also specifically authorized to release the health information described in paragraphs 2 and 3 to **[employer or its insurance carrier]** that is generated after the date that I sign this authorization, so long as this authorization is not expired or revoked.

5. I understand that I have the right to revoke this authorization at any time, I can do so by informing **[employer or its insurance carrier]** in writing, and that such revocation shall be effective except to the extent that action has been taken in reliance thereon. This authorization shall expire without express revocation one year after the date of signing.

6. I understand that health information released to another party may no longer be protected by federal privacy laws, and there is a risk that the information may be further used by the recipient

without the patient's consent.

7. A photocopy of this authorization shall be deemed as valid as the original.

Dated \_\_\_\_\_, 200\_.

\_\_\_\_\_  
Patient/authorized representative

If this document is signed by an authorized representative, state the authority to act for the patient here: \_\_\_\_\_.

NOTE: Patient's signature is required if the patient is fourteen (14) years of age or older and the records requested include information concerning mental illness or developmental disabilities. Patient's signature is required also if the patient is twelve (12) years of age or older and the records requested include information concerning alcohol or drug dependence/treatment.

This authorization has been drafted to comply with all applicable statutes, including Wis. Stats. § 51.30, § 146.81 and §146.82; 42 C.F.R. 2.31; and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations.