ASPIRUS™ CLINICS
Passion for excellence. Compassion for people.

Wausau, WI

Patient Label

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Previous last name(s) _____
Date of Birth _____ Phone Number _____
Address _____
City, State, Zip Code _____

***I authorize the use and/or disclosure of my protected health information:***

| FROM: | TO: |
|---|---|
| Name _____ | Name _____ |
| Organization _____ | Organization _____ |
| Address _____ | Address _____ |
| City, State, Zip _____ | City, State, Zip _____ |

**Information to be disclosed includes *(please initial)*:**

| | | | |
|---|---|---|---|
| _____All Clinic Records | _____Doctor Dictation | _____Neonatology | _____Other _____ |
| _____Allergy Records | _____X-ray Reports | _____Lab Reports | _____ |
| _____Immunization Records | _____X-ray Films | _____EKG Reports | _____ |
| _____Nurse Notes | _____Perinatology | | _____ |

**Dates of Service:** _____

**In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to *(please initial):***

_____Mental Health _____Developmental Disabilities _____Alcohol &/ or Drug Abuse _____HIV test results

**Dates of Service *(Specify):*** _____

**Purpose for disclosure:**

| | | | |
|---|---|---|---|
| ☐ Medical Care | ☐ Changing Physicians/ Providers | ☐ Disability Determination | ☐ Social Services |
| ☐ Insurance | | ☐ Worker's Compensation | ☐ Other (Specify) _____ |
| ☐ Legal | ☐ Personal | ☐ Law Enforcement | _____ |

**Further Disclosure:** I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

**Right to Revoke:** I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

**Right To Review:** I understand I have the right to inspect and receive a copy of the materials to be disclosed.

**Expiration:** This authorization is effective for six months from the date signed, or on occurrence of the following event:_____.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

***Patient Signature*** _____ ***Date*** _____

***Signature of Parent/Legal Representative/Relationship*** _____ ***Date*** _____