



**RUSK COUNTY MEMORIAL HOSPITAL AND NURSING HOME**

900 College Avenue West

Ladysmith, Wisconsin 54848

Phone 715/532-5561

**AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**AUTHORIZES:**

NAME OF PERSON OR ORGANIZATION \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY, STATE ZIP \_\_\_\_\_

**TO DISCLOSE PROTECTED HEALTH INFORMATION TO:**

NAME OF PERSON OR ORGANIZATION \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY, STATE ZIP \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**

DISCHARGE SUMMARY     HISTORY & PHYSICAL     CONSULTATION     OPERATIVE REPORT  
 PATHOLOGY REPORT     RADIOLOGY REPORT/FILMS     LABORATORY REPORT     REHAB NOTES  
 ER RECORD     OTHER: \_\_\_\_\_

**INFORMATION REQUIRING SPECIAL CONSENT:** In compliance with WI statutes, which require special authorization to disclose, otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

HIV/AIDS (including test results)     Mental/Behavioral Health Conditions     Drug/Alcohol Abuse /Treatment

**NOTE: USE & DISCLOSE OF PSYCHOTHERAPY NOTES REQUIRES A SEPARATE AUTHORIZATION**

**FOR THE FOLLOWING DATE:**

\_\_\_\_\_ FROM (DATE) \_\_\_\_\_ TO \_\_\_\_\_ OR \_\_\_\_\_ ALL DATES OF SERVICE

**PURPOSE OF USE & DISCLOSE (CHECK APPLICABLE CATEGORY):**

CONTINUITY OF CARE     INSURANCE CLAIMS     PERSONAL USE     LITIGATION  
 DISABILITY DETERMINATION     PRE/POST EMPLOYMENT     WORKERS COMPENSATION  
 OTHER (SPECIFY): \_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to inspect or Receive a Copy of the Health Information to be Disclosed** – I understand that I have a right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Refuse to Sign this Authorization**- I understand that I am under no obligation to sign this form and that Rusk County Memorial Hospital may not condition treatment, payment, enrollment of health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclose to a third party. **\*\*Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Rusk County Memorial Hospital. 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 made in reference to this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. **\*HIV Test Results:** I understand that 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. **\*\* WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes.

**EXPIRATION DATE: This authorization will remain in effect (check applicable category):**

FROM THE DATE OF SIGNATURE UNTIL THE \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.  
 UNTIL I CANCEL THIS AUTHORIZATION IN WRITING.  
 UNTIL THE FOLLOWING EVENT OCCURS, (SPECIFY EVENT): \_\_\_\_\_  
 OTHER (SPECIFY): \_\_\_\_\_

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Specify Relationship if Not Patient: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Date Records Released \_\_\_\_\_

\_\_\_\_\_  
Verification of Patient with Records Released  
(check when verified)

\_\_\_\_\_  
Staff Member Verifying Patient & Records  
(initial by staff member verifying)