Patient Name: _____

Maiden/Former Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

Clinic Number (if known): _____

GUNDERSEN HEALTH SYSTEM®

Learning and Developmental Diagnostic Clinic
1900 South Avenue, H03-003, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 52719 or (608) 775-2719
FAX: (608) 775-6692

I hereby authorize: Written Communication between 1 & 2? ☐ Yes ☐ No
Verbal Communication between 1 & 2? ☐ Yes ☐ No

1. **Information Disclosed From:**

_____
Name of Person or Organization (Gundersen Health System)

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

2. **Information Disclosed To:**

GUNDERSEN HEALTH SYSTEM
Name (Self, Person, Attorney, Insurance Co., etc.)

1900 SOUTH AVENUE
Street Address

LA CROSSE WI 54601
City State Zip

608-775-2719 608-775-6692
Phone Number Fax Number

3. **Please check one:**

☐ Mail Records ☐ Fax Records (provide fax number above) ☐ Will Pick Up Records in La Crosse
☐ No records needed at this time. File in patient's medical record for future use.

4. **Format for Records:** ☐ Paper **OR** ☐ DVD (requires PDF viewer). Please check only one box.
**Please note, if a format is not selected, records will be in paper format. **

5. **Type of Information to be Disclosed:** ☐ Medical Records ☐ Behavioral Health (#7 required) ☐ Both (#7 required)
☐ Other medical, please specify: _____
2 year history unless specified: _____ to _____

Type of Information to be Disclosed: ☐ All of the Following:

☐ Report Cards ☐ Regular Ed Records ☐ M-Team Reports ☐ IQ & Subtest Scores ☐ IEP
☐ Ind. Staff Reports ☐ Teacher Questionnaire ☐ Other educational, please specify: _____

Type of legal, human services, or other agency information to be disclosed: ☐ All of the Following:
☐ Case History ☐ Court Reports ☐ Counseling Records ☐ Other, please specify: _____

6. **State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed:**
☐ Mental Health ☐ Alcohol/Drug Abuse ☐ Developmental Disability ☐ HIV Testing

7. **Purpose or need for disclosure (check one):** ☐ Further Medical Care ☐ Insurance Claim ☐ Personal
☐ Legal Investigation ☐ Insurance Application ☐ Disability Determination ☑ Other: Diagnostic Evaluation

8. **Expiration Date:** This authorization is valid for 1 year from date of signature or until _____ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

Patient Name:_____

Maiden/Former Name:_____

Date of Birth:_____

Address:_____

_____

Phone Number:_____

Clinic Number (if known):_____

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Your Rights With Respect To This Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not limited to: Mental Health – Sec 51.30, Wis. Stats; & HFS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, HFS 92, Wis. Admin. Code; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties. Prohibition on redisclosure. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Right to Receive a Copy of this Authorization: I have a right to receive a copy of this form after I sign it. Right to Refuse to Sign This Authorization: I am under no legal obligation to sign this form, however, under certain circumstances permitted under applicable law; refusal to sign may result in denial of services. Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential. Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

In accordance with the conditions listed on the first page of this form and above, I authorize the use and disclosure of my medical information. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. This authorization may be revoked in writing at any time by submitting a request to Release of Information at the address above. ***Copies of records may be obtained with reasonable notice and payment of copying costs.***

Signature of Patient: _____ **Date**: _____

Signature of Parent/Guardian: _____ **Date**: _____
(If not signed by patient, identify relationship to patient. If Legal Guardian or other, provide a copy of the court order establishing the person's authority)

Legal Authority:

☐ Parent of Minor ☐ Legal Guardian ☐ Spouse of Deceased
☐ Personal Representative/Domestic Partner of Deceased
☐ Heath Care Agent: _____
☐ Other: _____

INTERNAL USE ONLY (Document PHI disclosed, date of disclosure and by whom.)