

GUNDERSEN
ST. JOSEPH'S
HOSPITAL AND CLINICS

Patient Name: _____
Maiden/Former Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Clinic Number: _____

Release Of Information
Gundersen St. Joseph's Hospital and Clinics
400 Water Avenue
Hillsboro, WI 54601
(608) 489 - 8131 or (608) 489 - 8356
Fax: (608)489-4899

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 re-disclosure. 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 re-disclosure 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. This form must be legible and the first page must be completed in full (numbers 1-9) in order to be valid. *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, provides 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
 Health Care Agent: _____
 Other: _____

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

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION