THE LAKES
COMMUNITY HEALTH CENTER

1-888-834-4551
thelakesCHC.org

☐ 719 E. Main Street Ashland, WI 54806 Phone: 715-685-2200 Fax: 715-685-2202

☐ 7665 U.S. Hwy. 2 Iron River, WI 54847 Phone: 715-372-5001 Fax: 715-372-5067

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________________, ______________

Patient Name: LAST FIRST MI — Date of Birth

I hereby authorize:
(Name and address of releasing facility)

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____
____

To: ☐ Release confidential **written** information to:
☐ Exchange confidential **verbal** information with:
(Individual name, facility/organization and address)

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____
____

Date & Time of Appointment ______________________________

PURPOSE OF DISCLOSURE:

- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use
- ☐ Coordination of Services
- ☐ Other (specify): ______________________________

By initialing below, I specifically authorize the release of all information regarding Alcohol and/or Drug Abuse, Behavioral Health, and HIV.

Initial

_____ Alcohol and/or Drug Abuse information
_____ Behavioral Health information
_____ HIV

INFORMATION TO BE RELEASED: Between Dates of: ______________ to ______________

☐ Discharge Summary	☐ X-Ray Reports	☐ Psychological Testing
☐ H&P Exam/Initial Evaluation	☐ X-Ray Films/MRI	☐ Transfer/Outside Information
☐ Consult	☐ Diagnostic Test Reports	☐ Completed Form
☐ CD Counselor/Therapist Reports	☐ Procedure Reports	☐ Exchange of Verbal Communication
☐ Progress Notes/Provider Notes	☐ Lab Reports/Pathology	☐ Dental Records
☐ Orders	☐ Correspondence	

☐ Other (specify content and dates): ______________________________
____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

I understand this consent for release of alcohol and/or drug abuse information is subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

Right to receive a copy of the health information to be used or disclosed - I understand that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorized form unless exceptions by WI Administrative Code HHS117.

Right to receive a copy of this authorization - I understand that I may receive a copy of this authorization form upon my request.

Right to refuse to sign this authorization - I understand that I am under no obligation to sign this form. Treatment, payment, enrollment in care is done soley for the purpose of creating information to release to another party. In these cases, care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers. If I refuse to sign the authorization for this purpose, I understand I may be responsible for paying the entire bill for services provided.

Right to revoke this authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact The Lakes Community Health Center. I am aware that my withdrawal will not affect releases of information that have already occurred subsequent to this authorization.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of minor ☐ Court appointed guardian/conservator

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Patient Signature — Date

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Signature of Authorized Person — Relationship to Patient