Southwest HEALTH

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label
Medical Record:_____
HAR:_____

Patient Name:
Date of Birth:
Address:
Phone Number:

SEND RECORDS FROM:

☐ **Southwest Health Hospital** 1400 East Side Road, Platteville, WI 53818	☐ **Southwest Behavioral Services** 1185 N. Elm Street, Platteville, WI 53818 or 1450 East Side Road, Platteville, WI 53818	☐ **Epione Pavilion** 808 S. Washington Street, Cuba City, WI 53807
☐ **Cuba City Clinic** 808 S. Washington Street, Cuba City, WI 53807	☐ **Platteville Clinic** 1450 East Side Road, Platteville, WI 53818	☐ **The Eye Center** 1450 East Side Road, Platteville, WI 53818
☐ **Other:**_____ Name of Organization	_____ Address or Phone/Fax	☐ **EMS** 1350 East Side Road, Platteville, WI 53818

SEND RECORDS TO: ☐ **Release records to MyChart**

Name:
Address:
Fax or pick up:

Records were released by unit: ☐ **Yes** ☐ **No**

_____
Staff completing form (PRINT Name and Location)

INFORMATION TO BE RELEASED:

Date(s) of treatment and/or specific illness/injury:_____

☐ Emergency Room Report	☐ History & Physical	☐ Discharge Summary	☐ Operative Report
☐ EKG	☐ Consultation	☐ Progress Note(s)	☐ Labs/Pathology
☐ Clinic Only	☐ Radiology Report	☐ Radiology Films/CD	☐ Rehab Therapy Records
☐ Nursing Home Records	☐ SBS *see below	☐ Eye Center	☐ Other:_____

PURPOSE OF DISCLOSURE: _____

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV Test results

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand this authorization will expire **one year** from today's date or the date identified:_____, whichever is sooner. Records will only be released up to the date of the signature.
- This authorization may be revoked in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Southwest Health will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Southwest Health records may include records that it receives from other organizations. If these records have been used by and filed in the record Southwest Health maintains about you, these records may be released with your Southwest Health records.
- Southwest Health cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Southwest Health from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____/_____/_____

(If signed by other than individual, state relationship with signature)

Updated: 3/22/18, 5/31/16, 7/31/15, 5/21/15, 6/25/14,