



**OAKLEAF
SURGICAL HOSPITAL**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Patient Name/Previous Name(s)

Date of Birth

Street Address, City, State, Zip Code

Phone Number

AUTHORIZES FROM:

OakLeaf Surgical Hospital
3802 W Oakwood Mall Dr
Eau Claire, WI 54701

RELEASE OF PROTECTED INFORMATION TO:

Name of Healthcare Provider/Other _____
Street Address _____
City, State, Zip Code _____
Verbal Exchange _____

INFORMATION TO BE DISCLOSED

Date of Service _____

___ History & Physical
___ Progress Notes
___ Discharge Summary
___ Consultations

___ Operative Reports
___ EKG Reports
___ Laboratory Reports
___ Pathology Reports

___ Medication List
___ Radiology Reports
___ Other / Please Specify

In compliance with Wisconsin Statutes, to release privileged information, please release records pertaining to:

___ Mental Health
___ HIV (AIDS)

___ Developmental Disabilities
___ Sexually Transmitted Disease

___ Alcoholism
___ Drug Abuse

PURPOSE OF DISCLOSURE

___ Further Medical Treatment
___ Insurance Eligibility/Benefits

___ Legal Investigation or Action
___ Changing Physicians

___ Personal

This information is to be: Mailed _____ Pickup _____ Verbal _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting OakLeaf Surgical Hospital. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact OakLeaf Surgical 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.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

Signature of Patient or Legal Representative/Relationship

Date

Driver's License, SS#, Other

Staff Verifying Identification

Staff Verifying ID (when released)