



Phone: 715.831.8130 ROI Fax: 715.952.0972



**REQUEST/ AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**PATIENT INFORMATION:**

\_\_\_\_\_  
Patient Name/Previous Name(s) Date of Birth Phone Number

\_\_\_\_\_  
Street Address, City, State, Zip Code

**RELEASE INFORMATION FROM:**

- OakLeaf Surgical Hospital- 1000 OakLeaf Way, Altoona, WI 54720
- River Prairie Surgery Center- 3119 Woodman Drive Altoona, WI 54720
- Both Facilities

**RELEASE INFORMATION TO:**

Self: **Delivery Options:**  Pick Up  Mail to address above  Fax \_\_\_\_\_  Email \_\_\_\_\_

**Format:**  Paper  Electronic Media

Send to Individual/ Healthcare Facility/Other:

Name: \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip Code \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**  Written  Verbal

**Date(s) of Service:** \_\_\_\_\_ (If left blank only information from last 2 years will be disclosed)

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Operative Reports  | <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Pathology Reports  | <input type="checkbox"/> Abstract    |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports   | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Consultations      | <input type="checkbox"/> Radiology Images/CD | <input type="checkbox"/> Laboratory Reports |                                      |
- (D/S Summary, H&P, Consult, Path, Operative Report, Lab, Radiology Implant)

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

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Developmental Disabilities   | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> HIV (AIDS)    | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Drug Abuse |

**PURPOSE OF DISCLOSURE:**

Continuation of Care  Legal Investigation  Insurance Benefits  Personal

**We may be prohibited from making certain information available to you or to your representative, including:**

Psychotherapy, Information related to medical research in which you have agreed to participate, Information related to legal proceedings, Information obtained under a promise of confidentiality, Information that federal or state laws prevent us from disclosing, Information for which the disclosure may result in harm or injury to your or to another person, Information related to certain lab results subject to CLIA.

**YOUR RIGHTS WITH RESPECT TO THIS REQUEST:**

Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide you with a written explanation of any restriction on the information that we can provide you. The organization 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. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to OLSH/ RPSC. I understand that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

**EXPIRATION:** This Authorization is good until the following date/event: \_\_\_\_\_  
Or if this item is left blank, the authorization will expire in 1 year from the date signed.

Signature of Patient or Legal Representative/Relationship \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Patient \_\_\_\_\_

01.09.2026

Staff Use: Staff Initials \_\_\_\_\_  ROI Send Records  Scan to Chart