Peter Christensen Health Center
129 Old Abe Road
Lac du Flambeau, WI 54538
Phone: (715) 588-3371
Fax: (715) 588-2039

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I. Patient Information:

Last Name:	First Name:	Middle Initial:
Address:	City / State / Zip Code:	Date of Birth:

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY OR ENTITY **Peter Christensen Health Center**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **129 Old Abe Road**	ADDRESS
CITY/STATE/ZIP **Lac du Flambeau, WI 54538**	CITY/STATE/ZIP
Phone: (715) 588-3371 **Fax: (715) 588-2039**	

III. The purpose or need for this disclosure is:

☐ Treatment / Continued Care ☐ Legal ☐ Transfer of Care ☐ Workers Compensation

☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Entire Record ☐ Clinic Notes ☐ Laboratory Reports ☐ History and Physical ☐ Hospital Discharge Summary ☐ Immunizations ☐ Prescriptions ☐ Radiology

In compliance with WI Statutes which requires special permission to disclose otherwise privileged information, I am authorizing that the following also be disclosed:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Test Results / Treatment

V. Right to Receive a copy of this Authorization – I understand that if I agree to sign this authorization, I will be provided with a copy. Right to Refuse to sign this Authorization- I understand that I am under no obligation to sign this form and that Peter Christensen Health Center may not condition treatment, payment and enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding, a.) Research related treatment, b.) Health plan enrollment or eligibility, c.) The provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. Right to Withdraw this Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Peter Christensen Health Center. 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. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. HIV Test Results: I understand my HIV test results may be released without authorization to persons/organizations that have access under State Law and a list of those persons/organizations is available upon request. ** WI Statutes 51.30, 146.83 and 252.15, requires patient authorization to disclose health information for payment purposes.

I understand a copy of this authorization is as valid as the original bearing my signature.
I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

This authorization is good for 12 months from the date signed (below my signature)

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)* DATE

IF not signed by subject of disclosure, specify basis for authority to sign:

☐ Parent of Minor ☐ Guardian ☐ Other Personal Representative (explain):