

Meriter Medical Clinic - Middleton
Medical Records Department
7780 Elmwood Ave., Suite 201
Middleton, WI 53562
(608) 417-3434

1. I HEREBY AUTHORIZE:

2. TO:

- Release information to:
- Obtain information from:
- Exchange information with:

Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

3. INFORMATION REGARDING: _____
(Print first and last name) (Date of birth)

(Indicate maiden name or previous names used)

4. PURPOSE OR NEED OF DISCLOSURE: (Check applicable categories)

- Further Medical Care
- Social Security Disability
- Application for insurance
- Legal Investigation or Action
- Obtain payment for insurance claims
- Vocational Rehabilitation Evaluation
- Patient's request (Personal Use)
- Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

5. TYPE OF INFORMATION TO BE DISCLOSED: (complete a through c)

- a. Records regarding treatment for: _____
- b. Records from the time period: _____
- c. Specific information requested: (please specify below)
 - Discharge summary
 - Cardiac testing
 - Emergency Room Record
 - History and Physical
 - Consultations
 - Therapy Notes (OT, PT, Speech)
 - X-ray _____ Lab
 - Anesthesia Records
 - Operative/Pathology Reports
 - Other (Specify): _____

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____

6. EXPIRATION DATE: This authorization shall be valid for one year unless otherwise stated or revoked through written notice to the Medical Records Department. Alternate date or event if not one year _____

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 the Medical Records Department. **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) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. **Right to Revoke This Authorization** - I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the Medical Records Department. I am aware that my revocation 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.

7. SIGNATURE OF PATIENT: _____ DATE SIGNED: _____

8. SIGNATURE OF AUTHORIZED PERSON: _____ DATE SIGNED: _____

(If applicable)

If signed by other than patient, state relationship and authority to do so.

Legal Authority: _____ Legal Guardian _____ Parent of minor _____ Next of Kin _____ Power of Attorney
(Attach court action) (Spouse, if living) (Attach POA papers)



02/03

Meriter Hospital
Madison, Wisconsin

**AUTHORIZATION/CONSENT FOR RELEASE OF
MEDICAL INFORMATION 611-28 808459**