



Part of the HealthPartners Family of Care

535 Hospital Road • New Richmond, Wisconsin 54017
715-246-2101

Authorization for Use and Disclosure of Health Information

(Individual/Patient/Client/Insured):

Name of Individual/Previous Name

Birth Date

Street Address

City, State, Zip Phone

AUTHORIZES:

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Westfields Hospital

Individual(s)/agency/organization making disclosure

Individual/agency/organization receiving information

535 Hospital Road

Street Address

Street Address

New Richmond, WI 54017

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE USED AND/OR DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed (e.g. history & physical, lab, xray, progress notes)

In compliance with WI Statues, which require special permission to release otherwise privileged information please release records pertaining to: (Check all that apply)

- Mental Health
- HIV test results
- Developmental Disabilities
- Other (Specify)_____
- Alcohol &/or Drug Abuse

For the Following Date(s): From _____ To _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- Further Medical Care
- Claims Resolution
- Coordinating Care for Dependent/Spouse
- Other (Specify)_____
- Insurance Eligibility/Benefits

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization—I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization**—I understand that I am under no obligation to sign this form and that Westfields Hospital may no condition treatment, payment, 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 (WI law requires patient’s authorization to disclosures records for payment purposes under

252.15 or 51.30) **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 Westfields Hospital. I am aware that my withdrawal will not be effective until received by Westfields Hospital and will not be effective regarding the uses and/or disclosures of my health information that Westfields Hospital has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides insurer with the right to contest a claim under the policy or the policy itself. **Marketing**—I understand if Westfields Hospital uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. **Right to Inspect or Copy the Health Information to Be Used or Disclosed**—I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 Health Information Department of Westfields Hospital.

REDISCLASURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event)_____. By signing this authorization, I am confirming that it accurately reflects my wishes.

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

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

(A photocopy of this authorization is as valid as the original)