AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

☐ **WVH–Chippewa Falls**
2175 E. Park Ave.
Chippewa Falls, WI 54729
(715) 720-6775 Fax (715) 720-6672

☐ **WVH–King**
N2665 County Rd. QQ
King, WI 54946-0600
☐ **Medical Records:**
(715) 258-5586 Ext. 2238
Fax (715) 256-3204
☐ **Admissions:**
(715) 258-5586
Fax (715) 256-3207

☐ **WVH–Union Grove**
21425 G Spring St.
Union Grove, WI 53182
Medical Records:
(262) 878-6702 Ext. 5531
Fax (262) 878-6778

1. _____ _____
Name of Member Birth Date

2. AUTHORIZES:

_____
Name of Health Care Provider

_____
Street Address

_____
City, State, Zip Code

3. RELEASE PROTECTED HEALTH INFORMATION TO:

_____
Name

_____
Street Address

_____
City, State, Zip Code

4. INFORMATION TO BE RELEASED:

Dates of Service _____

☐ History and Physical
☐ Medication Sheets
☐ Consultations Ophthalmological/Optometric
☐ Other (specify): Records

☐ Discharge Summary
☐ Laboratory Reports
☐ X-ray Reports

In compliance with Wisconsin and Federal Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health
☐ Alcoholism
☐ HIV (AIDS)
☐ Other (specify): _____

☐ Developmental Disabilities
☐ Drug Abuse
☐ Sexually Transmitted Diseases
☐ Sickle Cell Anemia

FOR THE FOLLOWING DATE(S): _____

5. PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

☐ Continuity of Care
☐ Insurance Eligibility/Benefits
☐ Other (specify): _____

☐ Personal
☐ Legal Investigation or Action

6. This form authorizes release of information in accordance with Wis. Statutes 51.30, 252.15, and 146.81-146.84 and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and 38 U.S.C. 5701 and 7332.

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.

You can print the most recent version of this form from the WDVA website at *www.WisVets.com/Forms.*

7. 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 Medical Records.
- **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, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Withdraw This Authorization —** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Medical Records. 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.

8. Expiration Date: This authorization is good until the following date(s) _____ or event(s)

(specify event) _____

A photocopied or faxed version of this authorization is as valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

9. Signatures:

Member: _____ Date: _____

If an "X" is used: _____ Date: _____

Witnessed By

Legal Authority: _____ Date: _____

Legal Authority: ☐ Legal Guardian
☐ Executor of Estate of Deceased
☐ Activated Power of Attorney

Legal Authority Has Presented Documentation That Member Is:
☐ Legally Incompetent (Court Documents)
☐ Deceased (Death Certificate)
☐ Legally Incapacitated (appropriate documentation as required by law to activate Power of Attorney–Health Care)