

THE DAVID CARE AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original

PATIENT

Patient Name/ Previous Names associated with Patient

Date of Birth or Medical Record Number

AUTHORIZES:

Street Address

City/State/Zip Code

APPLETON MEDICAL CENTER

1818 NORTH MEADE STREET

APPLETON WI 54911

Name of Receiver

Street Address

City/State/Zip Code

City/State/Zip Code

INFORMATION TO BE RELEASED INCLUDES:

Immunizations

X-ray reports (dates/type)

Discharge Summ

Lab Reports (dates/type)

Rehab Clinic Reports

History & Physical

HIV tests

Occup. Health Clinic Records

Consultations

Electrocardiogram (EKG)

Mental Health Records

Operative Reports

Cardiac Cath. Reports

Alcohol & Drug Abuse Records

ER reports dates/type

Doctors orders & progress notes: dates/type

Fit for Work Records

Other:

Copies of reports originating from other providers: Be specific:

Request release of original clinic record in its entirety moved to:

(Applies to within The David Care clinics only—not for any other use)

NEED FOR THE DISCLOSURE:

Changing Physicians/Relocation/Moving

Consultation/Further Medical Care

Disability Determination

Worker's Comp Injury

Legal Investigation

Personal

Payment Process/Insurance/Billing difficulties

Application for Insurance

Other:

I understand that if the person(s) and/or organization 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 re-disclosed without obtaining my authorization.

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 health information 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 so, 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 that 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 the health information department. 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.

EXPIRATION DATE: This authorization is good until the following date(s). By signing this authorization I am confirming that it accurately reflects my wishes. I have had opportunity to review and understand the content of this authorization form.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:

DATE: (If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by:

(Employee) Date:

Records Released: