AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

_____ _____
Name of Individual/Previous Names Birth Date

_____ _____(_____)_____
Street Address City, State, Zip, Phone

AUTHORIZES:

Beaver Dam Community Hospitals, Inc.
707 South University Avenue
Beaver Dam, Wisconsin 53916
920-887-4064 – Telephone
920-887-6691 - Facsimile

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

_____
Individual/agency/organization receiving information

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED:
[Check all that apply]

_____Cardiac Testing
_____Clinic Visit
_____Consultation
_____ Discharge Summary
_____ ER/UC
_____ History & Physical
_____ Laboratory Results
_____ Medical Imaging – Reports
_____ Medical Imaging - Images
_____ Operative Report
_____ Pathology Report
_____ Physician Documentation
_____ Rehabilitation Therapy
_____Other - _____

Pursuant to Wisconsin law requires, I specifically request the disclosure of the following records:
[Check all that apply]

_____Mental Health
_____Developmental Disabilities
_____Alcohol And Other Drug Abuse
_____HIV test results
_____Other (Specify):_____

For the Following Date(s): From_____ To_____.

PURPOSE OF DISCLOSURE:
(Check applicable categories)

_____At the request of the individual
_____Coordinating Care for Dependent/Spouse
_____Insurance Eligibility/Benefits
_____Claims Resolution
_____Further Medical Care [necessary for Alcohol &/or Drug Abuse per 42 CFR s. 2.2]
_____Other (Specify):

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.

1ROI

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Beaver Dam Community Hospitals, Inc. (BDCH) may not 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

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 Health Information Management at BDCH. I am aware that my withdrawal will not be effective until received by Health Information Management at BDCH and will not be effective regarding the uses and/or disclosures of my health information that Health Information Management at BDCH 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 the insurer with the right to contest a claim under the policy or the policy itself.

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 Health Information Management at BDCH.

REDISCLOSURE 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 with signature)

SIGNATURE OF WITNESS:
_____DATE:_____

Method by which patient's /legal representative's identify was confirmed:
_____Government issued photo identification
_____Other - _____

==========

I received copies of the information requested on this form.

_____ **_____**
Signature **Date**

_____ **_____**
Witness **Date**

==========

Revised 12-14-2018