Western Wisconsin Health
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Baldwin WI 54002
Phone: (715) 684-1590
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WRITTEN AND VERBAL RELEASE AUTHORIZATION:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, BOTH VERBALLY AND WRITTEN DOCUMENTATION, TO PERSONS INVOLVED IN MY CARE; All patients other than Inpatients.

Patient Name: _____
Address: _____ _____
Date of Birth: _____/_____/_____ Phone Number: _____ MRN # _____

I hereby give Western Wisconsin Health (WWH) my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions, written documentation or updates about my treatment, medications, or condition as requested. The purpose for these disclosures is to enable the persons below to assist me in maintaining my health, and to participate in my medical care.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that I may see and receive a copy of this form, if I request it, and that I may get a copy of this form after I sign it. ***Initials:*** _____

2. **The information disclosed may include matters regarding mental health, developmental disability, and alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, and medical correspondence and billing information. If you do not wish such information to be released, do not complete this form.** ***Initials:*** _____

3. The persons listed on this form may also view my chart (written documentation, films, and bills). ***Initials:*** _____

4. My records/films/bills can also be picked up at any time when filling out a medical authorization. ***Initials:*** _____

5. **I understand that I may revoke this authorization anytime by notifying Western Wisconsin Health in writing; however the revocation will not affect any actions which they have taken prior to the receipt of the revocation.** Without express written revocation directed to Western Wisconsin Health, I understand that this authorization will not expire during the remainder of my treatment period with Western Wisconsin Health, and until such time as I present Western Wisconsin Health with a written revocation of authorization, or complete a new authorization form. ***Initials:*** _____

6. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization receiving the information and may no longer be protected by federal privacy regulations upon re-disclosure. ***Initials:*** _____

_____ Signature of patient or patient's legal representative ***(Form MUST be completed prior to signing it)***	_____ Date
_____ Printed name of patient's representative	_____ Relationship to patient
_____ Witness	_____ Date