Beaver Dam Women's Health, LTD
705 S. University Avenue, Suite 300
Beaver Dam, WI 53916
Phone (920)885-6090
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**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**1. PATIENT:**

_____ Name of Patient

_____ Birthdate

_____ Street Address

_____ City, State, Zip

**2. AUTHORIZE:**

_____ Name of Physician/Healthcare Facility

_____ Street Address

_____ City, State, Zip Code

**3. RELEASE RECORDS TO:**

_____ Name of Physician/Healthcare Facility

_____ Street Address

_____ City, State, Zip Code

**4. INFORMATION TO BE RELEASED:**

_____Medical History, Examination, Reports
_____Treatment or Tests
_____Immunizations
_____X-ray Reports
_____Laboratory Reports
_____Entire Record
_____Surgical Reports
_____Hospital Records Including Reports
_____Allergy Records
_____Prescriptions
_____Consultations
_____Other (Specify):_____
_____

In compliance with Wisconsin 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

_____

FOR THE FOLLOWING DATE(S):_____

**5. PURPOSE OF DISCLOSURE: (Check applicable categories)**

_____Further Medical Care
_____Application for Insurance
_____Legal Investigation
_____Personal
_____Changing Physicians
_____Other (Specify):_____

**6.** I understand that if the person(s) listed above are not healthcare providers, health plans or healthcare 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.

**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 Beaver Dam Women's Health, Ltd.
- **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 organizations(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 healthcare 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 Beaver Dam Women's Health, Ltd. 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 organizations(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) _____ 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. Signature of Patient: _____** Date: _____
(If signed by person other than patient, state relationship and authority to do so)

Patient is: _____Minor _____ Incompetent _____ Disabled _____ Deceased

**Please Return To:**

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