



Authorization for Release of Patient-Identifiable Health Information

patient name _____

birthdate ____/____/____

I authorize the use or disclosure of the above-named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

The following individual or organization is authorized to receive the disclosure:

PRAIRIE CLINIC SC
name of physician / health care facility

name

112 Helen Street
street address

street address

Sauk City, WI 53583 ph:608-643-3351
city / state / zip fax: 608-643-8162

city / state / zip

- Purpose of the use or disclosure: Further medical care, Application for insurance, Legal Investigation, Self (personal use), Other (specify purpose)

Describe the type of information to be used or disclosed as follows:

a. Records regarding treatment for : b. Records from the time period:

c. Information requested:

- All records (or specify), Clinic visit notes, Lab reports, Consultations, Allergy Records, Immunization records, Electrocardiogram, X-ray reports, Other (specify), Health care information related to mental health, alcohol or drug abuse or a developmental disability, HIV test results.

- Right to Inspect or Copy the Information to be Used or Disclosed: I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Prairie Clinic SC's Privacy Officer.
Right to Receive a Copy of this Authorization: I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization upon request.
Redisclosure of Information by Recipient: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Prairie Clinic SC's Privacy Officer at (608) 643-3351.
Prohibition of Conditions: Prairie Clinic SC may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.
Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Prairie Clinic SC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Prairie Clinic, SC may charge a reasonable fee for copying records. Prairie Clinic, SC does not charge for copying and releasing records to another medical facility for further medical care.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

Signature of patient

Date

Signature of personal representation, person authorized by the patient, or other legal authority

Relationship / legal authority

FOR OFFICE USE ONLY: Received on ____ by ____ Processed on ____ by ____