WISCONSIN STATE PUBLIC DEFENDER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Patient Information:

Name: Date of Birth:

Any previous names:

I authorize the use and/or release of my protected health information as described in the paragraph five (5) below:

2. I Authorize:	**3. To release protected health information to:**
Name of person or organization:	Name of person or organization you want information released to:
Street Address:	Street address:
City, State, Zip Code:	City, State, Zip Code:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Email:	Email:

4. Purpose or need for disclosure:

Legal investigation Vocational Rehabilitation Patient's Request OTHER:

5. Types of information to be disclosed:

History and Physical Progress Summaries Laboratory Records
EKG/EMG/EEG
Problem List
Immunization
Emergency Room Records
Physical Therapy/Occupational Therapy/Speech Therapy

PA, NP, APNP Notes/Dictation
Physician Progress Notes/Dictation
Nurses Notes/Dictation
X-Ray/Medical Imaging
Operative/Procedure Report
Consultations
Mental Health Diagnosis/Treatment Information (Psychiatric & Psychological)

Pathology Report
AODA Diagnosis/Treatment Information
Social Work Notes/Dictation
Admission/Discharge Summaries
OTHER:

6. Records are requested for the following dates: to

This authorization may include disclosure of information regarding mental health/mental illness, developmental disabilities, alcohol and other drug treatment, AIDS or AIDS-related illness, and/or HIV test results unless specified as follows:

The records do not need to be certified unless specified as follows:

7. Expiration Date: This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. To specify an additional time period, please check one of the boxes below. If you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.

Other specific expiration date:
Other expiration event (specify):

8. Disclosure may be in the form of:

- Photocopies
- Fax
- Inspection
- CD/DVD
- Verbal Disclosure
- Email:

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 medical records department. Right to receive a copy of this authorization -- I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form. Re-release--I understand that the protected health information, once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA, and therefore, may no longer be protected by HIPAA. 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 listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. Right to revoke this authorization--I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the medical records department. I am aware that my revocation will not be effective as to use and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above. I intend that a photocopy of this authorization shall be as effective as the original.

9. Signature of Patient:
Date signed:

10. Person Authorized by Patient (if applicable):
Date signed:

If signed by other than the patient, state relationship and authority to do so:

Legal Authority:

- Attorney
- Legal Guardian
- Parent of Minor
- Spouse of Deceased
- Power of Attorney
- OTHER:

NOTE TO RELEASING ORGANIZATION/PERSON:
IF THE TOTAL COST OF THIS REQUEST IS OVER $50,
PLEASE CONTACT THE REQUESTOR PRIOR TO RELEASING THE RECORDS.