



## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**PATIENT:**

\_\_\_\_\_  
*Patient Name/Previous Name(s)*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City, State, Zip Code*

**AUTHORIZES FROM:****RELEASE OF PROTECTED INFORMATION TO:**

\_\_\_\_\_  
*Name of Health Care Provider/Plan/Other*

\_\_\_\_\_  
*Name of Health Care Provider/Plan/Other*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City, State, Zip Code*

\_\_\_\_\_  
*City, State, Zip, Code*

For the following dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**INFORMATION TO BE RELEASED:**

\_\_\_\_ Medical History, Examination, Reports      \_\_\_\_ Surgical Reports      \_\_\_\_ Immunizations  
\_\_\_\_ Treatment or Tests      \_\_\_\_ Hospital Records/Reports      \_\_\_\_ Radiology Reports      \_\_\_\_ Laboratory Reports  
\_\_\_\_ Consultations      \_\_\_\_ Other \_\_\_\_\_

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

\_\_\_\_ Mental Health      \_\_\_\_ Developmental Disabilities      \_\_\_\_ Alcohol & Other Drug Abuse  
\_\_\_\_ HIV (AIDS)      \_\_\_\_ Sexually Transmitted Disease Results      \_\_\_\_ Clinic Therapy (counseling) Notes  
\_\_\_\_ Mental Health Admission/Discharge Summary      \_\_\_\_ Mental Health Hospital Assessments/Notes

**PURPOSE OF DISCLOSURE:**

\_\_\_\_ Further Medical Treatment      \_\_\_\_ Legal Investigation/Action      \_\_\_\_ Personal  
\_\_\_\_ Insurance Eligibility/Benefits      \_\_\_\_ Changing Physicians  
\_\_\_\_ Other \_\_\_\_\_

**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 OakLeaf Clinics, Inc. 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 may 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) or organization(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 health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact OakLeaf Clinics, Inc. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.*

*Disclosure notice to recipient of mental health, alcohol and/or drug treatment records:  
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

**EXPIRATION DATE:** This authorization is good until the following date(s) \_\_\_\_\_ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

**Note:** A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

\_\_\_\_\_  
*Signature of Patient or Legal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Relationship (if not patient)*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*