Eau Claire City-County
Health Department

720 Second Ave, Eau Claire, WI 54703
www.echealthdepartment.org
P: 715-839-4718
F: 715-838-2643

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1.
Patient Name Date of Birth

Maiden Name (if applicable)

2. **AUTHORIZE:**

Name of provider/health care facility

Street address

City, State, Zip

Fax number

3. **TO RELEASE PROTECTED HEALTH INFORMATION TO:**

Name of provider/health care facility

Street address

City, State, Zip

Fax number

Check box if allowing mutual exchange of information between the above parties.

4. **HEALTH INFORMATION TO BE RELEASED:**

☐All Medical Records
☐ Lab reports, STD tests
☐ Date of last Depo Provera shot
☐ Treatment of abnormal pap/colposcopy and recommended follow-up
☐ Physical Exam, pap, breast exam from:
☐ X-ray reports, mammogram
☐ Colposcopy and biopsy results from:

Evaluation of the following medical problems:

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental health treatment
☐ Substance use treatment
☐ Family planning
☐ Other
☐ Developmental disability treatment
☐ HIV/ AIDS
☐ Sexually transmitted disease

5. **Purpose or need for disclosure:**

Further medical care
Referral by healthcare provider
Legal investigation
Other
Patient request
Insurance eligibility/benefits
Second opinion

6. This authorization will remain in effect until / / . If I do not indicate a date, this will expire one (1) year from the date of my signature. **I understand that:**

- **Information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**
- **Failure to sign this authorization form does not jeopardize my program participation.**
- **I have the right to revoke this authorization (in writing) at any time except to the extent that the Health Department has already acted on this authorization. I may arrange for this by contacting the Privacy Officer at 715-839-4718.**
- **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 for this by contacting the Privacy Officer at 715-839-4718.**
- **If I agree to sign this authorization (which I am not required to do) I must be given a signed copy of the form.**

7. **SIGNATURE:**

I have had full opportunity to read and consider the contents of this Authorization, and I confirm that by signing this authorization, the health care provider may use and or disclose to the persons named, the protected health information described in this form.

Signature: _____ Date: _____
Relationship to patient: _____
For Staff use only: Date Faxed _____ Mailed _____ INT _____

THIS FORM IS IN CONFORMITY WITH SECTION 146.81(2) AND 51.30, WIS. STATS. AND 45 CFR PART 164.508, EFFECTIVE APRIL 14, 2003.