Office Use Only:
MRN#:_____
Completion
Date/Initials:_____

Mail to: Tomah Health
Occupational Health and Wellness
501 Gopher Drive, Tomah, WI | **Fax:** (608) 377-8741
Phone: (608) 377-8784

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM TOMAH HEALTH

Patient Information:

Name:		Birthdate:
Address:		Telephone:
City:	State:	Zip Code:

Disclose To/Send To:

Name – (e.g. Health Facility, Insurance, Lawyer, Physician, Patient)
Address
City, State, Zip
Phone **Fax**

Pick up date (if picking up): _____

Medium: _____ Paper _____ CD _____ Fax to medical facility

Hospitalization/Treatments Dates: _____

Type or extent of information to be disclosed: (Check all that apply)

___ All Records date range _____ to_____
___ Audiogram
___ Pre-work Screen
___ BAT
___ Other: _____
___ Return to Work Form
___ DOT Physical
___ Drug Collection
___ Lab
___ TB Skin
___ Pre-employment Physical
___ Hazmat Physical

According to Wisconsin State Statutes, the categories listed below require special permission for release.
Please indicate for any of the following items that you wish to be released instead of or in addition to the items indicated above.

___ Mental/Behavioral Health
___ HIV Test Results
___ Developmental Disabilities
___ HIV Treatment records
___ Alcohol/ Drug Records
___ Sexually Transmitted Disease Test Results and Treatment Records

Note: There may be a charge for copies of Medical Records for purposes other than further medical care.

(Continued on back)

Purpose of Release: (*Only to be filled out for third-party request from hospital; not required if individual is requesting access to records*)

___ Further medical care ___ Application for insurance___ Personal ___ Law Enforcement
___ Payment of insurance claim ___ Disability determination ___ Legal
___ Medical Equipment/ Supplies ___ Ambulance Service ___ Media Release
___ Other: _____

I understand that if the person(s) and/or organization(s) listed above as the recipients of my protected health information are not health care providers or health plans (health insurance companies) that the information I am authorizing the release of may no longer be protected by the federal or state privacy standards and my health information may be re-disclosed without obtaining my authorization. I will hold harmless Tomah Health from and against any and all liability in connection with the disclosure of protected health information as authorized herein. I understand I may inspect and arrange for photocopies of the information that will be disclosed as a result of this authorization. This authorization will remain in effect to carry out the purpose for which it is intended, but will not remain in effect for dates of medical service beyond the stated expiration date. I understand if I do not specify an expiration date, the authorization will expire in one year from date signed. I understand that I may revoke this authorization at any time (except to the extent action has already been taken in good faith reliance on this authorization) by submitting a written request to Tomah Health. If I refuse to sign this authorization, my medical records/ information may not be released.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Person (if applicable) **Date**
This authorization will expire on the following date :_____(if not specified, expires in one year from signature date). Please note that regardless of expiration date, information will only be released for dates of medical service performed on or before the date of the signature of the patient or authorized person.

Relationship of Authorized Person Signature (if applicable):

___ Custodial Parent ___ Legal Guardian ___ Executor of Estate of Deceased

___ Power of Attorney for Healthcare* ___ Authorized Legal Representative* ___ Court Appointed Temporary Guardian

Patient is: ___ Minor ___ Incompetent ___ Disabled ___ Deceased ___ Incapacitated

*Must have written proof that representative is Power of Attorney for Healthcare or Authorized Legal Representative, and the document must state that the Authorized Person may obtain and / or sign for legal papers and/ or medical information. The patient must be legally incapacitated in order for the Power of Attorney for Healthcare to sign in place of the patient.

RIGHTS:

- **Right to Inspect or Copy the 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.
- **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.
- **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 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.
- **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 Tomah Health Information Services Department. I am aware that my withdrawal will not be effective for uses or disclosures made previous to my withdrawal. Tomah Health will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

A COPY OF THIS FORM IS AS VALID AS THE ORIGINAL.