

125 Hospital Drive Watertown, WI 53098 920-262-4210

Health Information Fax: 920-262-4266 Emergency Dept. Fax: 920-262-4360 Medical Record #

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

PATIENT'S NAME:	BIRTH D	DATE:PHONE NO:
ADDRESS:	CITY:	STATE:ZIP:
NAME OF PROVIDER OR ORG	ANIZATION <u>RELEASING</u> MEDICA	AL RECORD INFORMATION:
Watertown Regional Medical Ce	enter □ Hospital □ Clinic □ Both	h Provider Name (if applicable)
PERSON OR ORGANIZATION	TO RECEIVE THE MEDICAL REC	CORD INFORMATION (IF OTHER THAN PATIENT):
NAME:	ADDRESS:	CITY: STATE: ZIP:
PHONE:R	ECORD TRANSPORT: Pick up	☐ Mail ☐ Fax (for urgent requests only)
☐ HISTORY & PHYSICAL ☐ DISCHARGE SUMMAR ☐ OPERATIVE REPORT ☐ EMERGENCY RECORD ☐ CONSULTATION ☐ RADIOLOGY REPORTS THE PURPOSE OR NEED FOR ☐ FURTHER MEDICAL C. ☐ APPLICATION FOR INS ☐ DISABILITY DETERMING ☐ LEGAL INVESTIGATION YOUR RIGHTS WITH RESPEC authorization, I will be provided wit to sign this form and that Watertown authorization. Right to withdraw the statement of withdrawal to the WRM by the WRMC Privacy Office and we receipt of my withdrawal statement. right to inspect and/or receive a cop. I authorize the use and/or disclosure information pertaining to the diagnor Redisclosure notice-I understand the	□ EKG □ PULMONARY FUNC □ STRESS TEST DISCLOSURE IS: ARE □ PAYMENT OF INSUE BURANCE □ VOCATIONAL REHA NATION □ OTHER (SPECIFY): □ N TO THIS AUTHORIZATION: Right to a A Regional Medical Center (WRMC) ma A sis authorization-I understand that I hav MC Privacy Office by contacting 920-26. Will not be effective regarding the uses an Right to inspect and/ or copy my heal by of the information to be released and the of my protected health information as desist and/or treatment of mental illness, ale attentional interval in	RANCE CLAIM ABILITATION EVALUATION The condition to be used and/or disclosed-I understand that I have the that I will be charged a fee for any copies of the medical records that I received that I will be charged a fee for any copies of the medical records that I received that I will be charged a fee for any copies of the medical records that I received that I will be charged a fee for any copies of the medical records that I received that I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the chart I will be charged a fee for any copies of the medical records that I received the charged the charged that I will be charged a fee for any copies of the medical records that I received the charged that I will be charged a fee for any copies of the medical records that I received the charged that I will be charged the charged that I wi
DATE PATIENT'S SIG	GNATURE SIG	GNATURE OF PERSON LEGALLY AUTHORIZED TO SIGN FOR THE PATIENT
CHECK APPLICABLE AUTHORITY). POWER OF ATTORNEY COURT APPOINTED LE	RITY (ANY PERSON SIGNING FOR THE I	PATIENT MUST SPECIFY AND BE ABLE TO PROVIDE PROOF OF THEIR LEGAL ENT OF MINOR USE OF DECEASED PATIENT SED PATIENT'S IMMEDIATE FAMILY.
This authorization will remain in effective for an additional time pe	effect until the above disclosure(s) hav	ve been completed unless you specify that this authorization will be eriod, please NOTE that if you specify an additional time period this
Other specific expiration date or eve	ent (specify):	(mm/dd/yy)
OTHER (SPECIFY):	T 🗆 DISABLED 🗆 DECEASED	regarders is not to be released to other sources without easin scaling the permission of

NOTE TO RECIPIENT OF MEDICAL INFORMATION: The confidential information is not to be released to other sources without again seeking the permission of the patient.

NOTE TO RECIPIENT OF DRUG AND ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.

