Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM
323 S. 18th Ave. • Sturgeon Bay, WI 54235-1401

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient / Previous Name _____ Birth Date / Medical Record Number _____

Street Address _____ City, State, Zip Code, Phone Number _____

AUTHORIZES DISCLOSURE BY:

☐ Door County Medical Center

Or By: DCMC Clinic

☐ Sturgeon Bay ☐ Algoma ☐ Washington Island
☐ Fish Creek ☐ Southern Door

Name of Health Care Provider / Plan / Other _____

Street Address _____

City, State, Zip Code _____

DISCLOSURE OF HEALTH INFORMATION TO:

☐ Door County Medical Center

Or To: DCMC Clinic

☐ Sturgeon Bay ☐ Algoma ☐ Washington Island
☐ Fish Creek ☐ Southern Door

Name of Health Care Provider / Plan / Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

☐ Discharge Summary ☐ Pathology Report ☐ Consultation ☐ Operative Report
☐ History and Physical ☐ Radiology Report - Films ☐ Laboratory Report ☐ Rehab Notes
☐ ED Report ☐ Clinic Progress Notes ☐ Other: _____

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

☐ HIV / Aids* ☐ Mental / Behavioral Health Conditions ☐ Drug / Alcohol Abuse / Treatment

FOR THE FOLLOWING DATES: From: _____ To: _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care ☐ Personal Use ☐ Insurance / Claim Purposes ☐ Legal Investigation
☐ Disability Determination ☐ Vocational Rehab Eval ☐ Workers Compensation
☐ Changing Physicians ☐ Other: _____

YOUR RIGHTS WITH RESPECT TO THE AUTHORIZATION:

Right to Inspect or Receive a Copy of the Health Information to be Used or Disclosed – I understand that I have the right to inspect or receive a copy (at a reasonable fee) of 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, I must be provided with a copy. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that Door County Medical Center may not condition treatment, payment, **enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the disclosing facility (for DCMC contact the Health Information Department). I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. *HIV Test Results: I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. **WI Statutes 51.30 and 252.15 requires patient authorization to disclose health information for payment purposes.

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

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT / LEGAL REP.: _____ DATE: _____
(If signed by other than patient, state relationship and authority to do so.)

WITNESS _____

FOR ORGANIZATIONAL USE					
Dt Received:	Dt Disclosed:	Processed by:	☐ Mailed	☐ Faxed	☐ Picked Up By: