Riverview
MEDICAL CENTER

Patient Name: _____
Date of Birth: _____
Maiden Name: _____

Authorize: (Who has information you would like released?)

_____
Name

_____
Street Address

_____
City State Zip

To Disclose To: (To whom should the information be sent?)

_____
Name

_____
Street Address

_____
City State Zip

INFORMATION TO BE RELEASED:

_____ ER Record _____ Operative Note _____ Pathology Report _____ Lab
_____ History & Physical _____ Discharge Summary _____ Radiology Report _____ Therapy Records

Other (specify) _____

Specific Description on the above marked: _____

FOR THE TIME PERIOD OF: _____ TO _____

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

_____ Mental Health _____ Developmental Disabilities
_____ Alcohol Abuse _____ Drug Abuse
_____ HIV (AIDS) _____ Other _____

PURPOSE FOR DISCLOSURE:

_____ Further Medical Care _____ Payment of Ins. Claim _____ Legal Investigation
_____ Application for Insurance _____ Disability Determination _____ Moving
_____ Personal Use _____ Other _____
_____ Inspection of Health Care Records

I understand that this consent may be revoked by me at any time by written notice to the Medical Record Department, at the above address, except to the extent that action has been taken in reliance on this authorization. I have the right to inspect and receive a copy of the material to be disclosed.

I authorize release of my medical records in accordance with the specifications listed above. I understand that once this information is released, it may be subject to re-disclosure by the recipient and no longer be protected by the federal privacy law.

Initials:_____ I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

EXPIRATION DATE: This authorization is good for one year from date signed unless an earlier date is specified here _____

Signature of Patient _____ Date _____
(If signed by person other than patient, state relationship to patient)

Patient is: _____ Minor _____ Incompetent _____ Unable to Sign _____ Disabled _____ Deceased

Legal Authority: _____ Parent of Minor _____ Legal Guardian _____ Next of Kin of Deceased or Personal Representative

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Riverview Hospital Association reserves the right to charge for the copying of medical records

Please provide this completed and signed form to your current healthcare provider.