HudsonPhysicians

Authorization for Use and Disclosure of Patient Health Information

Name of Patient _____ Maiden or Previous Name _____ Birthdate _____

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

AUTHORIZE FROM:	***RELEASE INFORMATION TO:***
Name of Healthcare Facility _____	Name of Facility/Individual _____
Street Address _____	Street Address _____
City, State, Zip _____	City, State, Zip: _____
Telephone # _____ Fax#	Telephone # _____ Fax#:

METHOD OF DELIVERY: ☐Fax ☐Mail ☐Pick up_____ ☐Email _____

*For your convenience if your request if over 100 pages the request will be placed on a CD.

*Hudson Physicians will hold the requested medical records for 14 calendar days.

FOR THE FOLLOWING DATES:

From _____ to _____ Records Needed by (appointment date) _____

For specific record date(s):_____

INFORMATION TO BE RELEASED: ☐ **Entire Record** OR choose from the following

- ☐ Provider Notes
- ☐ Surgical reports
- ☐ X-ray reports
- ☐ Xray Imaging CD describe _____
- ☐ Medication List
- ☐ Laboratory Reports
- ☐ Immunizations
- ☐ Other (please specify) _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED - (as defined by applicable state and federal law)

- ☐ Mental health
- ☐ HIV (AIDS)
- ☐ Alcoholism
- ☐ Other (please specify):_____
- ☐ Developmental disabilities
- ☐ Sexual Transmitted Diseases
- ☐ Drug Abuse

PURPOSE OF DISCLOSURE:

☐ Personal Request ☐Transfer of Care ☐ Insurance ☐ Legal

☐ Other: _____

EXPIRATION:

This authorization expires on _____ . If left blank, the authorization will expire in one year from the date of signature.

I understand that Hudson Physicians will not condition my treatment on whether or not I sign this authorization form except (i) if the information to be disclosed will result from treatment for research purposes, Hudson Physicians will not provide the treatment if I am unwilling to sign this form; and (ii) if the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Hudson Physicians will not provide the treatment if I'm unwilling to sign this form. I understand that I have a right to revoke this authorization at any time by submitting a written request to the following address: Hudson Physicians, C/O Health Information, 403 Stageline Road, Hudson, WI 54016. I understand that any revocation will not have an effect on any actions Hudson Physicians took before it received the revocation. I understand that when Hudson discloses information pursuant to this Authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand that I may be charged a fee for the costs of copying records, subject to state law.

_____ Date

Patient or Patient Representative Signature (include relationship if other than patient)

Please present photo ID.

Office use only: Clinical/Business Office Staff (initials): _____ ROI/HIS Staff (initials):_____Photo ID Verified (date)_____