Hayward Area Memorial Hospital and Water's Edge
Authorization for Disclosure of Health Information:

PATIENT IDENTIFICATION (Please Print Complete and Full Address)

Full Name and Address:
Date of Birth (mm/dd/yyyy)
Phone Number:

Record Release From Provider:

Hayward Area Memorial Hospital
and Water's Edge
11040 N State Rd 77
Hayward, WI 54843
Phone #: 715-934-4259
Fax #: 715-934-4272

Records Released to:
(Requestor's Complete Name/Address)

Dates to be Released: _____.

Information to Be Disclosed:

O Discharge Summary O History and Physical O ER Record O Pathology O Operative Report
O X- ray/Nuclear Med O Therapy (OT, PT, SP, etc.) O X- Ray Films O Entire Record O Labs O Other (Specific) _____.

Purpose for Release of Information:

O Continued Care O Insurance O Legal Investigation O Personal O Disability
O Voc/Rehab O Workers Compensation O Workers Compensation Records Unrelated to Current Injury O Relocating O Other: _____.

Specific Authorization for Release of Information Protected by Federal or State Laws. A requestor is prohibited from making any further disclosure. Please mark all that apply:

O Substance / Alcohol Use O Mental Health Conditions O HIV Related Information and Testing O Disability

Your Rights in Respect to Authorization:

I give permission to the **Provider** to release the information above to the **Requestor**. I understand that if the person(s) and/or organization(s) listed above are not Healthcare Providers, Health Plans, or Healthcare Clearinghouses, the information disclosed to them may not be protected by federal privacy standards. Therefore, my healthcare information may be re-disclosed without obtaining my authorization. I understand that this authorization will take effect on the date signed and will be in effect for 1 Year **for the information specified above**. I understand that I can cancel this authorization at any time by notifying the **Provider** in writing. The cancellation will take effect when the **Provider** receives my written notice. I understand that my cancellation will not have any effect on the information received before the Provider receives my written notice. I understand that I have the right to inspect and /or receive a copy of the Health Information to be disclosed and a copy of this authorization. I understand that I have the right to refuse to sign this authorization and I understand that HAMH may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

Signature of Patient or Legal Guardian:

_____.

Relationship if other than patient: _____
Date (mm/dd/yyyy)_____**Records**: ○ **Mailed** ○ **Faxed** ○**Sent with Patient** ○**Sent** ○**Date Needed**

O **Photo ID Checked**. **Initials of person disclosing Information:** _____.

Revised 08/25/2010 **Fax/Printed copy serves as original**