**UnityPoint Health-Meriter**
**Hospital and Clinics**
Mail to:
Health Information Management
202 S. Park Street
Madison, WI 53715 (608) 417-6406

**Date released:** ___________
**Released by:** ___________
**# Pages:** ___________

1. Patient Name: ______________________
Date of Birth: ___________ Phone: ______________
Previous name (s): ______________________
Address: ______________________
(Street Address) (City) (State) (Zip Code)

I authorize the use and/or release of my protected health information as described in paragraph four (4) below.

**2. AUTHORIZE**:

______________________
(Name of person or organization) (i.e.: Meriter Hospital and Clinics)
______________________
(Street Address)
______________________
(City, State, Zip Code)

**3. RELEASE PROTECTED HEALTH INFORMATION TO:**
(if release is to Self, State Self):

______________________
(Name of person or organization you want information released to)
______________________
(Street Address)
______________________
(City, State, Zip Code)

**4. PURPOSE OR NEED OF DISCLOSURE:** (Check all that applies)

☐Further Medical Care ☐Social Security Disability ☐Application for Insurance
☐Legal Investigation or Action ☐Obtain Payment for Insurance Claims ☐Patient's Request (Personal Use)
☐Vocational Rehabilitation Evaluation ☐Continuity of Care Document (CCD) ☐Other (Specify): ___________

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

**5. TYPE OF INFORMATION TO BE DISCLOSED:** (complete a. through d.)

**a. Records regarding type of treatment:** ______________________
**b. Records from the time period:**______________________
**c. Records of related treatment that occurs after the date of my signature may / may not be released.**
**d. Specific information requested:** (please specify below)

☐Discharge Summary* ☐Cardiac Testing ☐Emergency Room Record ☐All Pertinent Information (see *)
☐History and Physical* ☐Consultations ☐Therapy Notes (OT, PT, Speech) ☐Operative/Pathology Reports*
☐X-ray* ☐Lab* ☐Anesthesia Records ☐ Medication List
☐Continuity Care Document ☐Other (Specify): ______________________

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: ______________________

**6. EXPIRATION DATE:** This authorization shall be valid for one year unless otherwise stated or revoked through written notice to the Health Information Management Department. Alternate date or event if not one year______________________

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Management Department. **Right to Receive Copy of This Authorization –** I understand that if I agree to sign this authorization. I have a right to receive a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. **Right to Revoke This Authorization -** I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the Health Information Management Department. I am aware that my revocation 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.

**7. SIGNATURE OF PATIENT:** ______________________**DATE SIGNED:** ______________

**8. SIGNATURE OF AUTHORIZED PERSON** (If applicable)**:** ______________________ **DATE SIGNED:**___________

If signed by other than patient, state relationship and authority to do so.

Legal Authority: ☐ Legal Guardian (Attach court action) ☐Next of Kin (Spouse, if living) ☐Power of Attorney(Attach POA for Health Care papers)
☐ Parent of Minor *Proper legal documentation must be on file.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**
**11/16 MR-FORM-0700 100025-1**

UnityPoint Health
Meriter