Fall General Surgery
Authorization for Release of Patient-Identifiable Health Information

Patient Name: _____
Medical Record #: _____
Patient DOB: _____

I authorize the use or disclosure of the above-named individual's health information as described below. I understand that I have the right to refuse to sign this authorization.

The following individual or organization is authorized to make the disclosure:

Individual/Organization Name:

_____

Address (street, city, state, zip code):

_____

_____

The following individual or organization is authorized to receive the disclosure:

Individual/Organization Name:

_____

Address (street, city, state, zip code):

_____

_____

Describe the type and amount of information to be used or disclosed as follows:

_____

_____

☐ **Health care information related to mental health, alcohol or drug abuse or a developmental disability**

☐ **HIV Test results** According to Wis. Stat. § 252.15, I have the right to request a list of releases made of my HIV test results without my consent.

Purpose of the use or disclosure: _____

Right to Inspect or Copy the Information to be Used or Disclosed
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Fall General Surgery's Privacy Officer.

(OVER)

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Right to Receive a Copy of this Authorization
I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Redisclosure of Information by Recipient
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Fall General Surgery's Privacy Officer at [address, phone number].

Prohibition of Conditions
Fall General Surgery may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Fall General Surgery. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if Fall General Surgery uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

Signature of patient or other legally authorized person:

_____

Date: _____

If signed by other legally authorized person, relationship to patient

_____