

405 Stageline Road. • Hudson, WI 54016 • 715-531-6000  
 Medical Records Department Fax: 715-531-6231  
 Imaging Center Fax: 715-531-6431  
 Emergency Center Fax: 715-531-6580  
 Programs for Change Fax: 715-531-6766

Hudson Hospital & Clinics Use Only	
MRN:	_____
MIN:	_____
Date Completed:	_____
ID Verified by:	_____
<input type="checkbox"/> Photo ID	<input type="checkbox"/> Signature

## AUTHORIZATION FOR RELEASE OF INFORMATION

<b>Name of Patient:</b> _____	<b>DOB:</b> _____
<b>Address:</b> _____	
<b>Phone:</b> _____	

This will authorize \_\_\_\_\_ to release information to:  
 (Name and address of organization to release records)

\_\_\_\_\_  
 (Name, Title and Address of person/organization to receive records)

<b>Preference:</b>		
<input type="checkbox"/> Mail to Recipient	<input type="checkbox"/> Pick up at Hospital (Date: _____)	<input type="checkbox"/> Other: _____

<b>The information is needed for the following purpose(s):</b>		
<input type="checkbox"/> Insurance	<input type="checkbox"/> Consultation	<input type="checkbox"/> Personal
<input type="checkbox"/> Disability	<input type="checkbox"/> Legal/Attorney	<input type="checkbox"/> Continuity of Care
<input type="checkbox"/> Other (please explain): _____		

Dates of Service Requested: \_\_\_\_\_

<b>Specific Reports Needed:</b>		
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Reports	<b>Alcohol &amp; Drug Abuse Records:</b>
<input type="checkbox"/> Emergency Care Reports	<input type="checkbox"/> Lab Report	
<input type="checkbox"/> Operative Report	<input type="checkbox"/> X-Ray Report	
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Radiology Films	
<input type="checkbox"/> Rehab (PT/OT/ST) Notes	<input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Assessment
		<input type="checkbox"/> Progress Notes
		<input type="checkbox"/> Discharge Summary
		<input type="checkbox"/> Other: _____

If Radiology Films is checked, please specify films needed: \_\_\_\_\_  **CD**

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Unless the records of your program are also subject to the Federal law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that Hudson Hospital & Clinics may not condition treatment or payment based on my decision to sign this form.

I understand that the authorized information may be subject to re-disclosure and may no longer be protected by state or federal privacy laws.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire twelve months following date of signature without my express revocation. A photocopy of this authorization shall be considered as valid as the original.

**I have the right to inspect and receive a copy of the material to be disclosed.**

\_\_\_\_\_  
 Patient, or person signing on behalf of patient

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to patient

\_\_\_\_\_  
 Witness