Scenic Bluffs
COMMUNITY HEALTH CENTERS

238 Front Street, Cashton, WI 54619
200 W. North St. Norwalk, WI 54648
(608) 654-5100, Fax (608) 654-5120

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION
(PLEASE COMPLETE IN FULL)

1. Patient information

_____
Name – Last, First, MI Maiden

_____
Street Address City State Zip Code

_____
Phone Number Date of Birth Patient Number (if known)

2. Records Disclosed From:
Scenic Bluffs Community Health Centers
___ Other (please specify): _____

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

3. Records Disclosed To:
Scenic Bluffs Community Health Centers
___ Other (please specify):_____
(i.e. Insurance Co., Lawyer, Physician, Self, etc.)

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

4. Type of information to be disclosed. (Check all categories that apply. Specify dates or time periods when known.)
A. ___ Medical history/diagnostic/therapeutic information from _____ to _____ including:
___ Mental Health ___ HIV ___ Developmental/Learning Disability ___ Drug/Alcohol Abuse
B. ___ Specific information (i.e., x-ray films, photographs) or verbal exchange with:
_____
C. ___ Medical information limited to: _____

5. Purpose or need for disclosure.
___ further medical care ___ payment of insurance claim ___ legal investigation
___ insurance application ___ vocational rehabilitation ___ personal
___ disability determination ___ other: _____

6. This authorization may be revoked in writing at any time prior to the disclosure of this information. This authorization will expire in six months from the date below unless you specify it will be effective for an additional period of time. (See reverse side for more information).
___ Include records generated during the additional time period. Specify: _____ None

By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed. **Copies of records may be obtained with reasonable notice and payment of copying costs.**

Signature of Patient: _____ Date: _____
If signed by a person other than the patient, state relationship and authority to do so. (See reverse side for signing authority).

Patient is: ___ Minor ___ Incompetent ___ Incapacitated ___ Deceased
Legal Authority: ___ Legal Guardian ___ Biological Parent of Minor
___ Spouse of Deceased ___ Health Care Agent
___ Personal Representative of Deceased
___ Other: _____

INTERNAL USE ONLY
(Document disclosed, date of disclosure and by whom.)

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Scenic Bluffs Community Health Centers recognizes the patient's right to confidentiality of patient health information. Therefore, you should be aware of the following guidelines when requesting medical records. The numbers listed below correspond to the numbered sections on the authorization.

4. Generally, all patients 18 years of age or older must sign for disclosure of their own health information. Read the following to determine exceptions for patients older or younger than 18 years of age.

a. All patients 18 years of age and over must sign for disclosure of health information, unless the following conditions apply.
   1) The patient is incompetent.
   2) The patient is incapacitated and cannot sign the form.
   3) The patient is deceased.

b. HIV Test Results.
   1) Wisconsin Law: All patients 14 years of age or older must sign for disclosure of HIV test results. Parental consent is not sufficient. For patients less than age 14, a parent or guardian may sign.
   2) Iowa Law Minor consent is not required.
   3) Minnesota Law: Test results are strictly confidential and may not be disclosed without the minor patient's consent.

c. Mental Health Treatment Records:
   1) Wisconsin Law: All patients 14 years of age or older may sign for disclosure of patient information involving treatment for mental illness or developmental disabilities. Parents generally may also consent, unless denied physical placement of the patient. When a parent consents for a patient 14 years of age or older, it is recommended that the patient sign also.
   2) Iowa Law: Parental consent is encouraged.
   3) Minnesota Law: All patients 16 years of age or older must sign for the disclosure of mental health care records.

d. Alcohol & Drug Abuse Treatment Records:
   1) Wisconsin Law: Patients 12 years of age or older must sign for the disclosure of alcohol & drug abuse records unless, the treating physician determines the minor lacks capacity, because of extreme youth or mental or physical conditions, to make a rational decision whether to consent to disclosure to parents is needed, or parental consent was required for the treatment in the first place.
   2) Iowa Law: Parents may not review or obtain copies of alcohol or drug abuse treatment records without minor patient's consent.
   3) Minnesota Law: Parents are entitled to notice or access to the minor's alcohol or drug abuse treatment records, unless the physician determines that his or her failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

e. When a patient is incapacitated, a person appointed as guardian or temporary guardian may sign with proper legal paperwork. If the patient has given written authorization to another person to disclose health information, the designated person can sign. Generally family members of living adult patients do not otherwise have authority to sign.

f. When the patient is deceased, the surviving spouse or personal representative, with proper legal paperwork, of the patient may sign authorizations disclosing health information. When there is no surviving spouse, immediate family may consent. For this purpose, immediate family is limited to adult children, parents, grandparents, adult brothers and adult sisters of the deceased patient and their spouses.

g. All persons signing for disclosure of health information, instead of the patient, must state their relationship to the patient and have available proof of legal authority to disclose health information. The above summary does not address all the complex exceptions that permit others to authorize disclosure.

6. Wisconsin Statutes recognize the need for informed consent. The patient may request multiple disclosures of the information stated on the authorization form. However, all disclosures based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for disclosure of patient health information for care provided after the date of the patient's signature, unless:
a. You check the "additional period" box and "include future records" box, or
b. You specify a different time period in **section 4.**