FOX VALLEY WELLNESS CENTER
180 KNIGHTS WAY
FOND DU LAC, WI 54935
FAX: 920-273-0480
TELEPHONE: 920-922-5433

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME_____ DOB_____

ADDRESS_____ PHONE (_____) _____

ORGANIZATION AUTHORIZED TO *DISCLOSE* PATIENT'S HEALTH INFORMATION

Fox Valley Wellness Center
NAME OF HEALTH CARE PROVIDER/OTHER

180 Knights Way
STREET ADDRESS

Fond du Lac, WI 54935
CITY/STATE/ZIP

ORGANIZATION or INDIVIDUAL AUTHORIZED TO *RECEIVE* PATIENT'S HEALTH INFORMATION

_____
NAME OF PERSON/ORGANIZATION/FACILITY

_____
STREET ADDRESS

_____
CITY/STATE/ZIP

HEALTH INFORMATION TO BE DISCLOSED_____

_____

PURPOSE FOR NEED OF DISCLOSURE (Check applicable information)

__ Further Medical Care __ Legal Investigations __ At the risk of the individual
__ Insurance eligibility/benefits __ Other_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION ARE SET FORTH ON THE BACK OF THIS AUTHORIZATION

EXPIRATION DATE: This authorization is good until the following date(s)/event_____
If there is no date or event specified, this authorization will expire one (1) year from the date signed

PROHIBITION OF RE-DISCLOSURE: This information is protected by Federal and Wisconsin Confidentiality laws. Such laws prohibit making any further disclosure of this information unless further Disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise Permitted by such laws. A general authorization for the release of medical or other information is **NOT** Sufficient for this purpose. The Federal rules (42C.F.R. Part 2) restrict any use of the information to Criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP._____ **DATE**_____

Relationship or authority to act for the patient_____
(If you are signing as a parent of a minor patient listed above, you are declaring that you have not Been denied physical placement of the child because such a placement would endanger the child's Physical, mental or emotional health)

WITNESS (when applicable) _____ Date_____

For office use only: Records picked up by_____ Date_____ Time_____ Initials_____

AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION INSTRUCTION SHEET

This authorization is not valid if one or more required elements are omitted.
Failure to complete this Authorization in its entirety will result in the denial of your request for us to disclose your/the patient's health information.

PATIENT INFORMATION: Fill in the complete name, address, date of birth and telephone number of the individual whose health information you are requesting to be disclosed.

PERSONS/ORGANIZATIONS AUTHORIZED TO DISCLOSE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

HEALTH INFORMATION TO BE DISCLOSED: You are not obligated to authorize a disclosure of your/the Patient's health information. You may wish authorized disclosure of as much or as little of your/the patient's Health information as you wishes.

PURPOSE FOR NEED OF DISCLOSURE: Check applicable category or provide other reason if not listed.

EXPIRATION DATE: This Authorization will be good for one (1) year unless otherwise specified. A valid Authorization must be signed and dated after the date of service or event has taken place

SIGNATURE AND DATE: It is your responsibility to review and understand this Authorization. If you have Any further questions about this Authorization, please contact Medical Records Department.

WITNESS (when applicable): When patient is physically unable to sign his/her entire signature.

You are required to sign and date this Authorization.

If you request health information that has been created after the date of this Authorization, you will Be required to complete another Authorization.

If you are a parent and have been denied physical placement of your child because it would endanger The child's physical, mental or emotional health, the law denies you access to obtain the child's health information.

A legal representative is a person authorized to obtain the patient's health information. This may include the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person who would be authorized in writing by the patient. Proof of such authority is required.

If no spouse survives a deceased patient, an adult member of the deceased patient's immediate family May qualify.

A court appointed temporary guardian to consent to the release of health information may also qualify. Proof of such guardianship is required.

Power of Attorney for Health Care takes effect upon finding that the patient is incapacitated. Two (2) Physicians or one (1) physician and one (1) psychologist, who personally examine that patient and sign a statement that the patient is incapacitated, make this determination. Proof of such Power of Attorney for Health Care is required.