

**St. Mary's HOSPITAL**  
 700 South Park Street  
 Madison, WI 53715  
 Health Information Services  
 (608)258-6689 Fax: (608)258-6329

Date copies needed by: \_\_\_\_\_  
 When copies are ready, please call:  
 \_\_\_\_\_  
 (phone number)

Patient Name \_\_\_\_\_  
 Last First Middle Initial Previous/Other  
 Address \_\_\_\_\_  
 Street City State Zip Code  
 Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

I authorize St. Marys Hospital Medical Center to disclose my protected health information to:

\_\_\_\_\_  
 Name of person or organization  
 \_\_\_\_\_  
 Street Address  
 \_\_\_\_\_  
 City State Zip Code

**Discharge Planning may include multiple facilities of the following type:**  
 Nursing Homes  
 Home Healthcare Agencies  
 CBRF  
 Other \_\_\_\_\_

The purpose of this disclosure is:  Further medical care  Legal  Disability determination  
 Insurance  OTHER (specify) \_\_\_\_\_

Type of Information to be used and/or disclosed: (complete one or more of the following)

- All records from the time period: \_\_\_\_\_
- The specific information listed here: \_\_\_\_\_  
 (Check applicable category)  
 All  Typed Reports [Includes Discharge Summary, History & Physical, consult(s), operation(s), diagnostic test(s)]
- OTHER (list) \_\_\_\_\_

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 here: \_\_\_\_\_

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

**Right To Receive Copy Of This Authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right To Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that St. Marys may not condition treatment on my decision to sign this authorization except regarding: (a) research-related treatment; or (b) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **Right To Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Health Information Services Department. I am aware that my withdrawal will not be effective until received by St. Marys and will not be effective regarding the uses and/or disclosures of my health information that St. Marys has initiated prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **Right To Inspect Or Copy The Health Information To Be Used Or Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 Services Department. **HIV Test Results** - I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

**REDISCLOSURE NOTICE** - I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. **Photocopies** - I understand that a photostatic copy shall be considered as valid as the original. **Expiration Date** - This authorization shall be valid for one year unless otherwise specified or revoked by me through written notice to the Health Information Services Department. If you want to limit or extend this authorization please indicate here; specify date and/or condition: \_\_\_\_\_

Signature of Patient/Legal Representative \_\_\_\_\_ Date Signed \_\_\_\_\_

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

- Patient is:  Minor  Incompetent  Disabled  Deceased  
 Legal Authority:  Parent of Minor  Power of Attorney for Health Care  Next of kin of deceased  Legal Guardian  
 (Attach legal document) (Must be spouse if living) (Attach proof of court action)

**ST. MARY'S HOSPITAL**

MADISON, WISCONSIN

111553 (09/03)

**Authorization for Disclosure of Health Information**

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