ASPIRUS™
Passion for excellence. Compassion for people.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Aspirus Hospitals

Patient Name_____ Previous last name(s)_____
Date of Birth _____ Phone # _____
Address _____
City, State, Zip Code _____

I authorize the use and/or disclosure of my protected health information:

FROM:	TO:
Name _____	Name _____
Organization _____	Organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

Information to be disclosed includes *(please initial)*:

_____Discharge Summary _____Lab Reports _____X-ray Films _____Other _____
_____History & Physical _____Emergency Record _____Verbal Exchange _____
_____Operative/Pathology Report _____X-ray Reports _____

Dates of Service: _____

In compliance with Michigan and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (please initial):

_____Mental Health _____Developmental Disabilities _____Alcohol &/or Drug Abuse _____HIV test results

Dates of Service *(Specify):* _____

Purpose for disclosure:

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal
- ☐ Changing Physicians/ Providers
- ☐ Personal
- ☐ Disability Determination
- ☐ Worker's Compensation
- ☐ Law Enforcement
- ☐ Social Services
- ☐ Other (Specify) _____

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand that I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event:_____.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

_____ _____
Signature of Patient ***Date***

_____ _____
Signature of Parent/Legal Representative/Relationship ***Date***