Hayward Area Memorial Hospital & Water's Edge

Right here in the place we love.

Authorization for Disclosure of Health Information

Patient Identification

Full Name & Address:	**Date of Birth:**
	Phone Number:

Records Released From:
Hayward Area Memorial Hospital & Water's Edge
11040 N State Road 77
Hayward, WI 54843
Phone: 715-934-4250/Fax: 715-934-4272

Records Released To: (Name/Address/Phone/Fax)

Dates of Service to be Released:_____

Information to be Disclosed:

- ○ ER Record
- ○ Radiology Disc
- ○ Orthopedic
- ○ Wound Care
- ○ Entire Record
- ○ History & Physical
- ○ Labs/Pathology
- ○ Urology
- ○ Pain Management
- ○ Other:_____
- ○ Discharge Summary
- ○ Operative Report
- ○ Podiatry
- ○ Oncology
- ○ Radiology Report
- ○ Therapy (PT, OT, ST)
- ○ General Surgery
- ○ Primary Care

Specific authorization for release of information is protected by Federal or State Laws. A requestor is prohibited from making any further disclosure. Please mark all that apply:

- ○ Substance/Alcohol Use
- ○ Mental Health
- ○ HIV/Info Testing
- ○ Disability

Your Rights in Respect to Authorization:
I give permission to the Provider to release the information above to the Requestor. I understand that if the person(s) and/or organization(s) listed above are not Healthcare Providers, Health Plans, or Healthcare Clearinghouses, the information disclosed to them may not be protected by federal privacy standards. Therefore, my healthcare information may be re-disclosed without obtaining my authorization. I understand that this authorization will take effect on the date signed and will be in effect for 1 Year for the information specified above. I understand that I can cancel this authorization at any time by notifying the Provider in writing. The cancellation will take effect when the Provider receives my written notice. I understand that my cancellation will not have any effect on the information received before the Provider receives my written notice. I understand that I have the right to inspect and /or receive a copy of the Health Information to be disclosed and a copy of this authorization. I understand that I have the right to refuse to sign this authorization and I understand that HAMH may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

Patient's/Legal Guardian's Signature:_____ **Date:**_____

Relationship if other than Patient:_____

Date of Request Completed:_____