Gundersen Lutheran

Health Information Management • 1900 South Avenue, La Crosse, WI 54601-5467
(800) 362-9567, Ext. 53199 or (608) 775-3199 • Fax (608) 775-4706

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 ______ Clinic Number (if known) ______

2. Records Disclosed From:

Gundersen Clinic, Ltd./Gundersen Lutheran Medical Center, Inc.

☐ Other(please specify): ______

Street Address ______

City ______ State ______ Zip Code ______

Phone Number ______ Fax Number ______

3. Records Disclosed To:

Name (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

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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 PHI disclosed, date of disclosure and by whom.)

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