

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) ,SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

Patient Name: Last: _____ Maiden: _____
 First: _____ Middle: _____

Address: _____

Date of Birth: _____ Sex: _____ Phone: _____ SSN: _____

I authorize the use or disclosure of the above named patient's health information as described below:

FROM:

Wheaton Franciscan Healthcare – All Saints
 3801 Spring Street
 Racine, WI 53405

Wheaton Franciscan Healthcare – All Saints
 1320 Wisconsin Avenue
 Racine, WI 53405

OTHER:

TO:

Name: _____

Address: _____

City, State, Zip: _____

FOR THE PURPOSE OF: (Check all that apply.)

- View Protected Health Information Only: Date _____ Time: _____
 Continued Care Legal Insurance Personal Use Other: _____

INFORMATION TO BE VIEWED AND/OR DISCLOSED:

- Date(s) of Service: _____
 Record Abstract (two year history of pertinent information unless stated above)
 Discharge Summary History & Physical Emergency Record Operative Record
 Lab Results, date or type: _____
 Radiology Reports/Images, date or type: _____
 Immunization Record Other: _____

PLEASE CHECK IF YOU DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

- HIV/AIDS (including test results) Substance Abuse Record Mental Health Treatment Records

I understand that the information in my health record may include information relating to mental health, drug and alcohol abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released. I understand that HIV test results may be disclosed without my permission in certain circumstances and that a list of such circumstances is available to me upon request. I further understand that I have a right to receive a copy of any to be disclosed.

I further understand that I have a right to inspect or receive a copy of any health information used or disclosed. I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

In support of your privacy, WFHC does not accept your blanket authorization to disclose Protected Health Information of treatment you have not yet received unless the authorization specifically requests release of information of further treatment of the condition treated in the originally requested episode. A new authorization will be required for each new episode of care.



Wheaton Franciscan Healthcare
 All Saints

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