

**AUTHORIZATION TO VIEW / DISCLOSE HEALTH INFORMATION**



Patient Name \_\_\_\_\_ MR Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

**I authorize the use or disclosure of the above named patient's Protected Health Information as described below:**

**FROM:**

**WHEATON FRANCISCAN HEALTHCARE:**

Wheaton Franciscan:  
 Elmbrook Memorial Campus  St. Joseph Campus  
 The Wisconsin Heart Hospital Campus

Wheaton Franciscan Healthcare:  
 Franklin  St. Francis  St. Michael

**OTHER:**

\_\_\_\_\_  
\_\_\_\_\_

**TO:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

Fax Number \_\_\_\_\_

**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:** \_\_\_\_\_ **to** \_\_\_\_\_ **or Type:** \_\_\_\_\_

- Record Abstract (two year history of pertinent information unless stated above)
- Discharge Summary  History & Physical  Operative Record  Lab Results
- Emergency Record  Immunization Record
- Radiology Reports/Images, dates or type: \_\_\_\_\_
- 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, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I understand that if I refuse to authorize the disclosure of this 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 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, WFH does not accept your blanket authorization to disclose Protected Health Information for 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.



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

