ELK MOUND POLICE DEPARTMENT
RELEASE OF MEDICAL INFORMATION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient _____ Birth Date _____

Street Address _____ City _____ State _____ Zip Code _____

AUTHORIZES:

Name or Names of Person or Facility _____

_____

_____

Street Address _____

City _____ State _____ Zip _____

Telephone # _____

TO DISCLOSE PROTECTED HEALTH INFORMATION TO:

Elk Mound Police Department
Dunn County District Attorney
Other Agencies Pertinent to Case
PO Box 188, E206 Menomonie St, Elk Mound, WI 54739
Fax # (715) 879-5851
Office # (715) 879-4411
Dispatch # (715) 232-1348

PROTECTED HEALTH INFORMATION TO BE USED

☐ Laboratory Reports ☐ Photographs ☐ Consults ☐ X-ray reports/films/slides ☐ ER Reports
☐ Surgical Reports ☐ Hospital Records ☐ Clinical Reports
☐ By a specific doctor or for a specific diagnosis (Name Doctor or Diagnosis) _____
☐ Any and all medical records of the above named patient relating to the diagnosis, prognosis or treatment of injuries or medical condition related to this case.
☐ Other, specify _____

TIME PERIOD FOR WHICH RECORDS ARE REQUESTED:

From: _____ To: _____ All _____

PURPOSE OF DISCLOSURE: Investigative Evidence for Case and Use in Trial.

EXPIRATION DATE: Expires automatically after 30 days unless checked below.

This authorization will remain in effect until (check applicable category);
☐ From the date this authorization is signed until the _____ day of _____ 20 _____
☐ Until I cancel this authorization in writing.
☐ Until the following event occurs, specify event: _____

In compliance with Wisconsin Law, which requires special permission to disclose otherwise privileged information, I specifically authorize the use and disclosure of my "Highly Confidential Information" selected above, if any. I have had an opportunity to review and understand the content of this authorization form, including the notices that appear on the back of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient Signature _____ Date _____

Signature of Patient's Legal Representative _____ Relationship to Patient _____

Witness Signature _____ Telephone # _____

Elk Mound Police Case Number: _____ Officer Name: _____

RE-DISCLOSURE NOTICE TO PATIENT: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organizations(s) re-disclose my health information.

DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS:

Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written consent of the person who is the subject of such records.

DISCLOSURE NOTICE TO RECIPIENT OF MENTAL HEALTH, ALCOHOL AND/OR DRUG TREATMENT RECORDS:

This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to receive copy of this authorization –** I understand that if I sign this authorization, I will be provides with a copy of this authorization
- **Right to refuse to sign this authorization –** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above may not condition response to my compliant on my failure to authorize.
- **Right to inspect a copy of the health information to be used or disclosed –** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Management (medical records) department of the facility involved.
- **HIV test results –** I understand my HIV test results maybe released without authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available.
- **Mental health treatment records –** I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative code.

RIGHT TO WITHDRAW THIS AUTHORIZATION:

- You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Chippewa County Sheriff's Office. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organizations(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest under policy or the policy itself.