ROCK RIVER
COMMUNITY CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(TO OBTAIN INFORMATION FROM ANOTHER SOURCE)

PATIENT INFORMATION:

Name of Patient/Previous Names Date of Birth

Street Address

City, State, Zip

Phone Number

AUTHORIZES DISCLOSURE BY:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

Phone:_____ Fax:_____

FOR THE FOLLOWING DATES:

DISCLOSURE OF HEALTH INFORMATION TO:
Rock River Community Clinic

☐ 1461 W. Main Street STE B
Whitewater, WI 53190
P: 262-472-6839
F: 262-472-6802

☐ 415 S. Eighth Street STE 3
Watertown, WI 53094
P: 920-206-7797
F: 920-206-0870

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed.*

☐ Hospital Records ☐ ED Report (last 3) ☐ Patient Demographics
☐ Specialty Clinic notes ☐ Lab Report (3 years) ☐ Current medication and allergy list
☐ Progress report (past year) ☐ Radiology Report ☐ Healthcare Power of Attorney

DISCLOSURES REQUIRING SPECIAL CONSENT: *In compliance with Federal/Wisconsin Statutes, which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed: Check that apply.*

☐ Drug/Alcohol Abuse/Treatment ☐ HIV/AIDS ☐ Mental Health/Behavioral Health Conditions

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continue Care ☐ Disability Determination ☐ Legal ☐ Workers Compensation
☐ Transfer to New Provider ☐ Insurance/Claim Purposes ☐ Vocational Rehab.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed -- I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive a Copy of This Authorization** -- I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** -- I understand that I am under no obligation to sign this form and that Rock River Community Clinic may not condition treatment, payment, enrollment, in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care is solely for the purpose of creating PHI for disclosure to a third party. ****Right to Withdraw This Authorization** -- I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Rock River Community Clinic's Health Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the Federal privacy standards. ***HIV Test Results**: I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request. ****WI Statutes 5130 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy of Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any of information to criminally investigate or prosecute any alcohol or drug abuse patient.
Expiration Date: This authorization is good until the following dates _____ or 1 year from the date signed.

Signature of Patient/Legal Rep:	Relationship to Patient:	Date:
RRCC Employee Witness:		Date:

RELEASE BY: ☐ US MAIL ☐ FAX:

New Patient Appointment:

STAT