Lac Courte Oreilles Community Health Center
13380 W. Trepania Rd., Hayward, WI 54843
Phone: 715-638-5100 Fax: 715-634-2740

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:** _____
Phone Number: _____

RECORDS RELEASED FROM:	**RECORDS RELEASED TO:**
_____	_____
_____	_____
_____	_____

Information to be Released: Service Dates Between _____**to**_____

__Discharge Summary __History and Physical __ER Record __Imaging Reports __Labs __Pathology
__Operative/Procedure Reports __Therapy (OT, PT, Speech) __Radiology Films/MRI __ Entire Medical Record
__Other (specify content) _____

PURPOSE OF DISCLOSURE: __ Continued Care __ Worker's Compensation __ Payment of Claim
__ Disability __ Legal __ Relocating __ School __ Personal Use
__ Other (specify) _____

If you would like any of the following sensitive information disclosed, check the applicable section(s) below:

__ Alcohol/Drug Abuse Treatment/Referral __ Behavioral Health Information (Other than Psychotherapy Notes)
__ HIV/AIDS-related Treatment __ Sexually Transmitted Diseases
__ Psychotherapy Notes ONLY (by checking this box, I am waiving any Psychotherapist-Patient privilege)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying LCOCHC in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that LCOCHC may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand that I have a right to inspect and receive a copy of the material to be disclosed.
- I understand that I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that my HIV test results may be released without my authorization to persons/organizations that have access under Wisconsin Law, and that a list of those persons/organizations is available upon request.
- I understand a photocopy or fax of this form is the same as the original.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

If I am signing as Authorized Representative of the patient, I am: □ Parent of Minor □ Court appointed guardian/conservator

Patient Signature: _____ Date: _____

Signature of Authorized Person: _____ Date: _____

Record was: □ Mailed □ Faxed □ Sent with Patient □ Picked up in person Date: _____ Initials: _____ JDG 9/14/2023