CROSSING RIVERS HEALTH
37868 US HWY 18, PRAIRIE DU CHIEN, WISCONSIN 53821
PHONE (608) 357-2000

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

1. Patient Information

____
Name – Last, first, MI | Maiden

____
Street Address | City | State | Zip Code

____
Phone Number | Date of Birth | Medical Record Number

2. Records Disclosed From:

Crossing Rivers Health
Organization Making Disclosure

37868 US Hwy 18
Street Address

Prairie du Chien WI 53821
City | State | Zip Code

3. Records Disclosed To:

____
Organization/Person Receiving Information

____
Street Address

____
City | State | Zip Code

4. Type of Information to be Disclosed:

The following is a specific description of the health information I authorize to be disclosed (include date(s) or condition(s)): ______________________________

____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: (Check all that apply)

☐ Mental Health ☐ HIV/AIDS ☐ Alcohol and/or Drug Abuse ☐ Developmental Disabilities

5. Purpose or need for disclosure:

☐ further medical care ☐ payment of insurance claim ☐ legal investigation
☐ insurance application ☐ vocational rehabilitation evaluation ☐ personal
☐ disability determination ☐ other: (describe): ______________________________

I understand treatment, payment, enrollment, or eligibility of benefits may not be conditioned on signing this authorization. When the information is used or disclosed by the authorized recipient, it may be subject to re-disclosure and no longer protected by the privacy rule. I have the right to inspect and receive a copy of the material to be disclosed. Copies of records may be obtained with reasonable notice and payment of copying costs. This authorization may be revoked in writing at any time prior to disclosure of this information. This authorization will expire six months from the date of signature. A photocopy of this authorization is considered as valid as the original.

Signature of Patient______________________________ Date______________

Signature of Legal Representative______________________________ Date______________

Relationship to Patient______________________________

Records copied and sent by______________________________ Date______________