CROSSING RIVERS HEALTH CLINIC
37822 US Hwy 18 Prairie du Chien, WI 53821
Phone: (608) 326-1072 Fax: (608) 326-1076

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

2. Records Disclosed From:

Records Disclosed To:
Crossing Rivers Health Clinic
37822 US Hwy 18
Prairie du Chien, WI 53821

3. 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 Statues, which require special permission to release otherwise privileged information, please release records pertaining to: (Circle all that apply).

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

4. Purpose or need for disclosure: (Circle all that apply).

Further Medical Care	Payment of Ins. Claim	Legal Investigation
Insurance Application	Vocational Rehab Eval	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 _____