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

Patient Information				
Name – Last, first, MI		Maiden		
Street Address		City	State	Zip Code
Phone Number		Date of Birth		
Records Disclosed From:		Records Disclosed To: Crossing Rivers Health Clinic 37822 US Hwy 18 Prairie du Chien, WI 53821		
Type of Information to The following is a specific of		th information I authorize to be di	isclosed (include (date(s) or condition(s)):
In compliance with Wisconelease records pertaining		require special permission to	release otherwise	e privileged information, p
_				e privileged information, p Developmental Disabilities
release records pertaining Mental Health	to: (Circle all that ap	pply). Alcohol and/or Drug A		
release records pertaining Mental Health	to: (Circle all that ap	pply). Alcohol and/or Drug A	buse Le	Developmental Disabilities egal Investigation ersonal
Mental Health Purpose or need for disc Further Medical Care Insurance Application Disability Determination I understand treatment, payr information is used or discle rule. I have the right to insp notice and payment of copy	HIV/AIDS closure: (Circle all the ment, enrollment, or elosed by the authorized ect and receive a copying costs. This authorise	at apply). Payment of Ins. Claim Vocational Rehab Eval	buse Le Pe conditioned on sign disclosure and no Copies of records n at any time prior	Developmental Disabilities egal Investigation ersonal ning this authorization. When longer protected by the priva nay be obtained with reasona to disclosure of this informat
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