CUMBERLAND HEALTHCARE

1705 16th Avenue, Cumberland, WI 54829
Hospital Main: (715) 822-7500 ● Fax (715) 822-7151

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name/Previous Name _____ Date of Birth _____ Telephone Number _____

AUTHORIZES: _____
Individual/Agency/Organization Making Disclosure

DISCLOSES TO: _____ _____
Name/Address Name of Provider/Plan/Other Phone Number

_____ _____
Street Address Fax Number

_____
City, State, Zip Code

INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES: _____ **TO** _____

Identify the specific information you are authorizing to be disclosed.

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Radiology Report
- ☐ Laboratory Report
- ☐ Rehabilitation Notes
- ☐ Emergency Room
- ☐ Radiology Images
- ☐ Immunization Records
- ☐ Ambulance Report
- ☐ Other: _____

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with WI Statutes, which require special permission to release otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- ☐ Mental/Behavioral Health Information
- ☐ Alcohol/Drug Abuse
- ☐ HIV Test Results*

PURPOSE FOR DISCLOSURE (Check applicable categories)

- ☐ At the Request of the Individual
- ☐ Further Medical Care
- ☐ Insurance Eligibility/Benefits
- ☐ Claims Resolution
- ☐ Transfer of Care
- ☐ Other (Specify): _____

Cumberland Healthcare is on Ambra for receiving radiology images. Please upload your DICOM images to https://chc-wi.ambrahealth.com/share/CHC-54829

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive a Copy of This Authorization — I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refusal to Sign This Authorization — I understand that I am under no obligation to sign this form and that Cumberland Healthcare may not condition treatment or payment on my decision to sign or not to sign this authorization.

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 Cumberland Healthcare. I am aware that my withdrawal will not be effective until received by Cumberland Healthcare and will not be effective regarding the uses and/or disclosure of my health information that Cumberland Healthcare has made prior to receipt of my withdrawal statement.

Marketing — I understand if Cumberland Healthcare uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information.

Right to Inspect or Copy the Health Information to Be Used or Disclosed — I understand that I have the right to inspect or copy (provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Department.

***HIV Test Results** — I understand my HIV test results may be released without authorization to persons/organizations that have access under State law. **WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes.

Re-Disclosure Notice — I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(if signed by other than individuals, state relationship with signature)

_____ **DATE:** _____
(Relationship)

FOR ORGANIZATIONAL USE

Date Received: _____ Date Disclosed: _____ Processed By: _____ Mailed ☐ Faxed ☐ Picked Up By: _____