LAKESHORE community health care

Authorization for Disclosure

MRN: _____
Office Use Only

Name | Date of Birth | Phone number | Previous Name(s)

Address | City | State | Zip

AUTHORIZES:

☐ Releases to
☐ Obtain from

Lakeshore Community Health Care
P.O. Box 959
Sheboygan, Wisconsin 53082

Phone: 920-783-6633 ext 245
Fax: 920-783-6805
Email: HIM@lakeshorechc.org

☐ Releases to
☐ Obtain from

Name of Medical Provider/ Dental Provider/Facility/Other

Address | City | State | Zip

Phone Number | Fax Number

Email Address

1 ▶ **DATE(S) OF INFORMATION TO BE DISCLOSED:** From: _____ to _____
Month/Year Month/Year
if left blank, information from past two (2) years will be disclosed.

INFORMATION TO BE DISCLOSED: ☐ Verbal ☐ Written ☐ Exchange

- ☐ Clinical Notes
- ☐ Lab Results
- ☐ Imaging Results
- ☐ Medication Profile
- ☐ Mental Health/AODA Records
- ☐ Identify/Presence in Treatment
- ☐ Dental Clinical Notes
- ☐ Dental Radiographs
- ☐ Billing
- ☐ Other _____
- ☐ Select if you DO NOT authorize HIV Results to be disclosed

EXPIRATION: This Authorization is good until the following date: _____

PURPOSES: ☐ Care Coordination ☐ Further Follow-up Care ☐ Personal ☐ Insurance Eligibility/Benefits ☐ Veryify Compliance with Treatment

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

2 ▶ **SIGNATURE OF PATIENT:** _____ DATE: _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ DATE: _____

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority is: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for health care

* By signing above, I hereby declare that I have not been denied physical placement of child.

Processed by (initials): _____ Date: _____