Spooner HEALTH

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information	NAME: _____ Office Use Only MRN_____ Date of Birth: _____ Day phone: _____
Health Care provider or hospital who has the information that you want released?	NAME/ORGANIZATION: _____ Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip code: _____
Where do you want the information to be sent?	NAME/ORGANIZATION: _____ Attn: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip code: _____
What are the approximate dates of information you want released? What do you want released?	Service Dates Between _____ to _____ Send CHECKED Records only ☐ Memory Clinic Report ☐ Neuropsychological Testing Report
How do you want the information?	Release Method/Format requested: ☐ Paper copy (mailed) ☐Pick-up (Photo ID required at pick-up time) ☐Fax

- This authorization lasts for one year after the date you sign unless you enter a different date here: _____
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that Spooner Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy if this form after I have signed it.
- I understand that in compliance with WI Administrative Code HHS117, Federal Rule 45 CFR 164.524; charges may apply. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original

Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation.	_____ Patient Signature _____ Date	_____ Signature of Authorized Person ☐ Court-appointed guardian/conservator Include legal documentation Date: _____

Mail to: Spooner Health HIS Department 1280 Chandler Drive Spooner, WI 54801 Phone: 715-939-1737 Fax: 715-939-1559	OFFICE USE ONLY: Records Released: __ Yes __ No Released By: _____ Release Date: _____