PATIENT AUTHORIZATION FOR THE RELEASE OF MEDICAL or BILLING INFORMATION FROM THE WISCONSIN STATE LABORATORY OF HYGIENE

Patient should complete **all** sections below. Directions provided on the back of this form.
Please retain a copy of the completed form for your records.

1.
I hereby authorize personally identifiable medical information be released only as described below. <u>This authorization will expire once the request has been fulfilled.</u>

Print the patient's name: ____

Signature of patient or personal representative: ______________________ Date: ________

Print your name: ____________________ Your relationship to patient: ____________

Street Address: ____________________ City ___________ State ____ Zip __________

2a.
What medical information do you want released? Please provide as much information as you can.

Name of the test(s) or slides*: ______________________
____

Date(s) the sample was collected: ______________________
____

Name of physician who ordered the test: ______________________________
Clinic/Hospital where sample was collected: ______________________________
Address of Clinic/Hospital: ______________________________
____
State the purpose for this release: ______________________________
* NOTE: Specimens will be released only to medical personnel. If slides are requested, they must be returned to the WSLH.

2b.
What billing records do you want released? Please provide as much information as you can

Account name: ____________________ Account number: ____________________
Patient name: ____________________ Dates of service: ____________________
State the purpose for this release: ______________________________

3.
To whom do you want this information released?

___ Provide this information to me directly at:
Street Address:______________________________
City: ____________________ State:__________ Zip: ________

___ Provide this information to:
Name of person: ______________________________
Title (if appropriate) ______________________________
Agency name (if appropriate): ______________________________
Street Address: ______________________________
City: ____________________ State: __________ Zip: ________

4.
For WSLH Office Use Only:
Phone # & Name of Staff Person Disclosing Information:______________________ Date of Disclosure:____________

HIPAA form WSLH D to be used with HIPAA policy UW 3.2

PATIENT INSTRUCTIONS:

- You have the right to refuse to sign the authorization. Except as permitted under applicable law, WI State Laboratory of Hygiene may not refuse to provide healthcare and billing services if you refuse to sign this form.

- You may review or request a copy of the personally identifiable medical information to be used or released, with certain exceptions provided under state and federal law. A fee may be charged for the costs of copying and mailing the information requested.

- A copy of your signed authorization will be mailed to you and the person(s)/organization(s) receiving your medical information.

- If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

- You have the right to revoke this authorization in writing by sending a written notification to:

  Wisconsin State Laboratory of Hygiene
  Peggy Hintzman, Associate Director
  465 Henry Mall
  Madison WI 53706-1578

- The revocation is not effective if the notification is received after the release of information has occurred, or if the authorization is linked to obtaining insurance coverage.

- If we are unable to fulfill your request, you will be informed in writing.

Please mail or fax to: Records Manager
Wisconsin State Laboratory of Hygiene
465 Henry Mall
Madison WI 53706-1578
Fax Number: 608-262-3257

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If you have any questions or need assistance in completing this form, please contact WSLH Administration Office at: 608-262-3911 or 1-888-494-4324