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. This authorization will expire once the request has been fulfilled.

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: _____

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 <u>in writing</u> by sending a written notification to:

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

- The revocation is not effective if the notification is received <u>after</u> 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.

- If you request records in-person, picture identification in the form of a government ID (e.g. driver's license, passport, military ID) is required.

- Individuals requesting records over the phone will be required to complete this form.

- *Personal Representative for an adult or an emancipated minor must be a person with legal authority to make health care decisions on behalf of the individual. For an unemancipated minor, the personal representative must be a parent, guardian, or other person acting in loco parentis with legal authority to make health care decisions on behalf of the minor child. For the deceased, a personal representative must have legal authority to act on behalf of the decedent or the estate (not restricted to persons with authority to make health care decisions).

Please mail or fax to: Records Manager
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If you have any questions or need assistance in completing this form, please contact WSLH Administration Office at: 608-890-0288 or 1-888-494-4324.