Access
COMMUNITY HEALTH CENTERS℠
Improving health. Improving lives.

**Return authorization to:**
Release of Information
8501 Excelsior Drive
Madison, WI 53717

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____ _____
Patient Name Date of Birth Phone

AUTHORIZES DISCLOSURE FROM:

Access Community Health Centers
Attn: Medical Records
2901 W. Beltline Hwy
Madison, WI 53713

TO RELEASE MEDICAL INFORMATION TO:

_____
Name of Health Provider/Organization/Individual

_____
Street Address

_____
City State Zip

## PURPOSE OF THIS DISCLOSURE:

☐ Transferring to New Physician/Continued Health Care (Customary to release up to 2 years of most recent information)
☐ Insurance Application ☐ Disability Determination ☐ Legal Investigation
☐ Personal Use ☐ Other, please specify _____

## INFORMATION TO BE DISCLOSED:

Date Range: _____ to _____

☐ Office Visit Notes ☐ Immunization Records ☐ Radiology Reports ☐ Radiology Media
☐ Laboratory Reports ☐ Complete Copy of Official Medical Record ☐ Electronic copy of records requested
☐ Specific information pertaining to: _____

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**YOUR RIGHTS REGARDING THIS AUTHORIZATION**

**Right to inspect or receive a copy of the health information to be used or disclosed**: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

**Right to receive a copy of this authorization**: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

**Right to refuse to sign this authorization**: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

**Right to withdraw this authorization**: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Access Community Health Centers. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. Access Community Health Centers will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

**Further Disclosure**: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may be released electronically.

**Expiration Date**: This authorization is effective for one (1) year from the date signed unless otherwise indicated. → _____
Date

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. My signature also authorizes the release of information related to AIDS/HIV, mental health care and treatment, alcohol or drug use and developmental disabilities, except for the following exception: _____

_____ _____
Patient or Legal Representative Signature / Relationship Date of Signature