AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name:	Date of Birth:
Street Address:	City/State/Zip Code:

Authorizes:

Facility Name:_____
Street Address:_____
City/State/Zip Code:_____
Fax#:_____

To Release Health Information to:

DeFatta Health
1490 Rivers Edge Trail
Altoona, WI 54720
Fax#: 715.839.7796

MEDICAL RECORDS AUTHORIZED TO BE RELEASED:

☐ All Allergy Records	☐ All ENT (Ears, Nose, Throat) Records	☐ Surgical Reports
☐ Radiology Reports	☐ Medical History	☐ Hospital Records
☐ Audiology Records	☐ Lab Results	☐ All Records

Records to be released for the following date(s):_____

PURPOSE FOR NEED OF DISCLOSURE:

☐ Continuation of Medical Care	☐ Insurance Eligibility
☐ Personal	☐ Other:

I, the undersigned, understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization.**

I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand that after my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that my authorization will remain effective from the date of my signature until (date)_____, and that the information will be handled confidentially in compliance with all applicable federal laws. I also understand that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

Signature of Patient/Guardian:_____

Printed Name:_____ Date:_____