AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

RE: _____ DATE OF BIRTH: _____

TO: Individual(s)/agency/organization making disclosure:

_____

_____

_____

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

The Dodge County Sheriff's Office and the Dodge County District Attorney's Office

information from my/the patient's protected health information and medical records relating to patient identity, diagnosis, prognosis or treatment for the purpose of a legal investigation.

Please return all records to: Dodge County Sheriff's Office, 124 West Street, Juneau, WI 53039

The type of information to be disclosed includes:

☐ CERTIFIED records regarding treatment for: _____

☐ CERTIFIED records for the time period: _____

Format for records and information to be disclosed: Records and information may be disclosed in any format including, but not limited to, written, verbal and electronic and may be transmitted by any means including, but not limited to, facsimile, email, telephonic means or U.S. Mail.

The information to be released may include (Check all that apply): ☐ psychiatric, ☐ developmental disability, ☐ alcohol abuse, ☐ drug abuse, ☐ HIV test results, ☐ .AIDS or AIDS related disease diagnosis.

This information is protected by federal and Wisconsin confidentiality laws. Such laws prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by such laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ I hereby authorize release of such information.

☐ I do not authorize release of such information.

This authorization shall be valid for two years unless otherwise revoked through written notice to the releasing agency. A copy of this consent shall be as valid as the original.

When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION: I understand that if I sign this authorization, I will be provided with a copy of this authorization.
RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION: I understand that I am under no obligation to sign this form and that a covered entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.
RIGHT TO WITHDRAW THIS AUTHORIZATION - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the disclosing individual(s)/agency/organization. I am aware that my withdrawal will not be effective until received by the disclosing individual(s)/agency/organization, and will not be effective regarding the uses and/or disclosures of my health information that the disclosing individual(s)/agency/organization has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED: I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the disclosing individual(s)/agency/organization.
HIV TEST RESULTS: I understand my HIV test results may be released without authorization to persons/organizations that have access under state law and a list of those persons/organizations is available upon request.
REDISCLOSURE NOTICE: I further understand that information used or disclosed based on this authorization may be shared with other law enforcement agencies and prosecutors, parties to any resulting criminal prosecution and may be used in the course of any court proceeding related to the information or record(s) so disclosed and I consent to such redisclosure.

Dated:_____ _____

Patient or Authorized Person

If signed by person other than patient, state authority to do so below:
☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin, spouse if living ☐ Power of Attorney

A photocopy of this authorization shall be deemed sufficient.