405 Stageline Road. • Hudson, WI 54016 • 715-531-6000
Medical Records Department Fax: 715-531-6231
Imaging Center Fax: 715-531-6431
Emergency Center Fax: 715-531-6580

Hudson Hospital & Clinics Use Only	
MRN: ____________________________	
MIN: ____________________________	
Date Completed: _____________________	
ID Verified by: ______________________	
☐ Photo ID	☐ Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ____ **DOB:** ___________________
Address: ____
Phone: ___________________

This will authorize ____ to release information to:
(Name and address of organization to release records)

____
(Name, Title and Address of person/organization to receive records)

Preference:		
☐ Mail to Recipient	☐ Pick up at Hospital (Date: ______)	☐ Other: ___________________

The information is needed for the following purpose(s):		
☐ Insurance	☐ Consultation	☐ Personal
☐ Disability	☐ Legal/Attorney	☐ Continuity of Care
☐ Other (please explain): ____		

Dates of Service Requested: ____

Specific Reports Needed:		
☐ Discharge Summary	☐ Consultation Reports	**Alcohol & Drug Abuse Records:**
☐ Emergency Care Reports	☐ Lab Report	☐ Assessment
☐ Operative Report	☐ X-Ray Report	☐ Progress Notes
☐ History and Physical Exam	☐ Radiology Films	☐ Discharge Summary
☐ Rehab (PT/OT/ST) Notes	☐ Other: ___________________	☐ Other: ___________________

If Radiology Films is checked, please specify films needed: ____________________________________ ☐ **CD**

I may refuse to sign and my refusal will not affect my ability to obtain treatment.

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Unless the records of your program are also subject to the Federal law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire twelve months following date of signature without my express revocation. A photocopy of this authorization shall be considered as valid as the original.

I have the right to inspect and receive a copy of the material to be disclosed.

_________________________________ _________________________
Patient, or person signing on behalf of patient Date

_________________________________ _________________________
Relationship to patient Witness