

**Authorization for General Disclosure of
Patient Health Information****PATIENT INFORMATION:**

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Telephone Number: _____

INFORMATION TO BE DISCLOSED BY: Children's Wisconsin Children's Community Services Children's Medical Group Other: _____**INFORMATION GIVEN TO/SHARED WITH:**

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

REASON INFORMATION BEING SHARED:

INFORMATION TO BE SHARED:

EXPIRATION DATE: This Authorization is valid until the following date/event: (not to exceed 3 years) _____
If no date is listed, this authorization is good for three (3) years from the date signed below.**SIGNATURE**

I have read, understand and agree to the information above and on the back of this form. I am legally able to authorize the sharing of my/the child's patient health information, and by signing below I hereby give my authorization.

Patient, Parent or Legal Representative Signature_____
Date_____
Relationship to Child

**PLEASE READ THE FOLLOWING BEFORE VOLUNTARILY SIGNING THE FRONT OF THIS
DISCLOSURE FORM**

NOTICE OF PRIVACY PRACTICES: You have been given a copy of the Children's Hospital of Wisconsin Notice of Privacy Practices which describes the rights of Children's Hospital of Wisconsin and yourself to disclose patient information.

SUBSEQUENT RELEASE: You are aware that the patient information may potentially be re-disclosed by the recipient and may no longer be protected by United States of State confidentiality laws.

RIGHT TO REFUSE TO SIGN: You understand that this authorization is voluntary and that you may refuse to sign it, in which case Children's Hospital of Wisconsin will not release the patient information specified in this form. Your decision to not sign the authorization will not affect your child's ability to receive any viable treatments available to your child.

REVOCACTION: You understand that you have the right to revoke this authorization at anytime. Your revocation must be sent in writing to the Director, Health Information Management, P.O. Box 1997, Milwaukee, WI 53201. Your revocation will not apply to any patient information already released in response to this, or any other, authorization.

LIABILITY: All members of the workforce of Children's Hospital of Wisconsin, as described in the Children's Hospital of Wisconsin Notice of Privacy Practices, are released from any and all legal responsibilities for the release of information as specified in this form.

COPY: You will be provided a copy of this form after you sign it and it is accepted by Children's Hospital of Wisconsin.