1. I authorize the use and disclosure of the following health record information as described below.

2. The following individual or organization is authorized to make the disclosure:
   Upland Hills Health, 800 Compassion Way, Dodgeville, Wisconsin 53533.

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate.)

   _____

   _____

   _____

   From (date) _____ to (date) _____

4. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or AIDS related diseases, human immunodeficiency virus (HIV), test results or sexually transmitted diseases. It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse and test results, or developmental disabilities.**

5. This information may be disclosed to and used by the following individual or organization:
   Name person/organization: _____
   Address: _____
   For the Purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
   If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management at Upland Hills Health.

8. I understand that Upland Hills Health may receive direct or indirect payment from a third party payer related to this authorization.

9. A photocopy of this signed authorization is as valid as the original.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
If signed by Legal Representative, Relationship to Patient	Signature of Witness

Upland Hills Health, 800 Compassion Way, Dodgeville, Wisconsin 53533
608-930-8000

DISCLOSURE OF HEALTH INFORMATION AUTHORIZATION

Patient Name: _____

Date of Birth: _____

Medical Record #: _____