Sixteenth Street
COMMUNITY HEALTH CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

I, , authorize

(Printed Name of Patient and DOB)

☐ 16th Street Community Health Center
1032 S. Cesar Chavez Drive
Milwaukee, WI 52302

☐ Other Facility/ Health Care Provider/ Person
Name
Address

To release medical records information to:

☐ 16th Street Community Health Center
Fax to (414) 672-4265

☐ Other Facility/ Health Care Provider/ Person

This information will include my identity, diagnosis and treatment, including psychiatric, psychological, alcohol, substance abuse, genetic testing, sexually transmitted disease, infections diseases and/or AIDS/HIV related records maintained by this facility and/or other Entity.

Specific type of information to be released or being requested, including treatment/exam dates:

☐ Abstract/Summary of all care
☐ Progress Notes from to
☐ Newborn records
☐ All (2 years unless noted)
☐ Behavioral Health Records
☐ Prenatal/OB Records
☐ Immunization Records
☐ Other:
☐ Labs from to
☐ X-rays from to
☐ ED visit/Summary on

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of SSCHC in the following manner:

☐ Continuing care ☐ Legal reasons ☐ Other:

This authorization shall be in force and effect for <u>one year following the date of signature</u> unless another date has been specified. I understand that I have the right to revoke this authorization in writing, at any time, by sending written notification to SSCHC or to the "Other" releasing entity. I understand that a revocation is not effective towards information previously released under authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that re-disclosed information would be more complete and accurate if provided by the originating healthcare provider. I understand that I have the right to inspect and receive a copy of the information to be used/released. I understand that Behavioral Health Providers will be given the opportunity to review and restrict the release of notes in an effort to avoid unnecessary disclosure. I understand that I may refuse to sign this form and that such refusal will not keep me from receiving treatment or payment/enrollment for benefits. If I have any questions, I understand I can contact the Medical Records Department.

If I have received electronic records on a "flash drive", I understand that the information is not protected by encryption and therefore all personal health information contained therein is available to the holder of said flash drive. I understand the risk and agree that I am taking personal responsibility for the information contained in the flash drive

Date _____ Signature of Patient (Patient may sign if 14 years or older) _____

Date _____ Parent or Legal Guardian/Relationship to Patient _____

Date _____ Witness _____

☐ Consent translated by qualified staff Requesting SSCHC Provider initials ID used for pick up