Hanna Medical Clinic
3207 Laura Ln Suite 105
Middleton, WI 53562
608-203-8022
Fax: 608-203-8041

Authorization for the Release of Confidential Health Information

HANNA MEDICAL CLINIC

Complete the following form to authorize the release of information that you indicate in the sections below.

Name-Person whose records will be released (record subject):

Address:

Phone number:

Date of Birth:

Name -The entity/organization you authorize to release information FROM (include full address, phone and fax#):

Address:

Phone:

Fax:

Name- the entity/organization you authorize to release information TO (include full address, phone and fax#, if other than Hanna Medical Clinic)

Address:

Phone:

Fax:

Provide Specific Description of records authorized for release (indicate dates of records as necesaryssary):_____
_____
_____
_____
_____
_____

- ☐ Summary of chart
- ☐ XRays/ Radiology Images
- ☐ Test results/labs/EKG
- ☐ Records pertaining to:
- ☐ Other:

Hanna Medical Clinic
3207 Laura Ln Suite 105
Middleton, WI 53562
608-203-8022
Fax: 608-203-8041

Authorization for the Release of Confidential Health Information

HANNA MEDICAL CLINIC

Complete the following form to authorize the release of information that you indicate in the sections below.

Purpose or Need for Release of Information (be specific): _____
_____
_____
_____
_____

☐ **Continuation of Care**

***Substance Use Disorder (SUD) Records will only be released if indicated here.**

☐ SUD assessments
☐ Treatment notes and treatment plans
☐ Lab screening results
☐ Discharge Summary including SUD information
☐ All SUD information from date ____/____/____ to date ____/____/____

☐ Other:

- The information that I authorize to be released is voluntary.
- Refusal to sign will not affect treatment.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release the information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Signature of Patient/Representative:_____

Date:_____

If signed by representative, print name and state relationship to patient:

_____

*Authorization expires as of (date): _____