# AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

**(PLEASE COMPLETE IN FULL.** Please use Adobe Acrobat Reader to complete this form.)

**1. Patient Information**

Name – Last, First, MI _____ Maiden _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____ Clinic Number (if known) _____

**2. Records Disclosed From: (Check One)**

☐ Gundersen Clinic, Ltd.
Gundersen Lutheran Medical Center, Inc.

☐ Franciscan Skemp Healthcare Center

☐ Other (please specify):_____

**3. Records Disclosed To:**
LA CROSSE DISTRICT ATTORNEY
333 VINE STREET, ROOM 1100
LA CROSSE, WI 54601

(608) 785-9604 FAX: (608) 789-4853

**4. Type of information to be disclosed.** (Check all categories that apply. Specify dates or time periods when known.)

A. ☐ Medical history/diagnostic/therapeutic information from _____ to _____ Including:
☐ Mental Health ☐ HIV ☐ Developmental/Learning Disability ☐ Drug/Alcohol Abuse

B. ☐ Specific Information:_____
☐ Verbal Exchange ☐ Radiology Films ☐ Radiology Reports ☐ Hospital Notes ☐ Clinic Notes

☐ Photographs ☐ Physical Trauma Body Map ☐ Strangulation Checklist

☐ Domestic Abuse Forensic Nurse Form ☐ Sexual Assault Documentation Form

☐ Other, please specify:_____

**5. Purpose or need for disclosure.**
☐ Legal investigation or action ☐ Other:_____

**6. This authorization may be revoked in writing at any time prior to the disclosure of this information. This authorization will expire in six months from the date below unless you specify it will be effective for an additional period of time.**
☐ Include records generated during the additional time period. Specify: _____
☐ None

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By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive copy of the material to be disclosed. **Copies of records may be obtained from the treatment facility with reasonable notice and payment of copying costs. A photocopy of this authorization is considered as valid as the original.**

**Signature of Patient:**_____ **Date:**_____
If signed by a person other than the patient, state relationship and authority to do so.

Patient is: ☐ Minor ☐ Incompetent ☐ Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Biological Parent of Minor ☐ Spouse of Deceased ☐ Health Care Agent
☐ Personal Representative of Deceased ☐ Other:_____

Print Form