Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

AUTHORIZATION TO TRANSFER PATIENT RECORDS TO STURGEON BAY CLINIC FOR CONTINUING CARE

323 South 18 Avenue – Sturgeon Bay, WI 54235
Phone: 920-746-3650 Ext. 3081 – Fax: 920-746-3534

PATIENT INFORMATION:

Name of Patient/Previous Names _____ Birth Date _____ Phone Number _____

Street Address _____ City, State, Zip Code _____

AUTHORIZES DISCLOSURE OF HEALTH INFORMATION TO DOOR COUNTY MEDICAL CENTER FROM:

Name of Health Care Provider _____ Street Address _____

City, State, Zip Code _____ Phone/Fax Number if Applicable _____

INFORMATION TO BE DISCLOSED: *Identify below information you are authorizing to be disclosed to DCMC.* Check (√) all that apply.

- ❑ Hospitalizations *if Within Last Year*
- ❑ Most Recent Colonoscopy
- ❑ Most Recent Mammogram
- ❑ Laboratory Reports *if Within Last Year*
- ❑ Emergency Dept. Reports
- ❑ Most Recent Annual Wellness/Physical Exam
- ❑ Vaccination Records
- ❑ Other: _____

AND/OR FOR THE FOLLOWING DATES: From: _____ To: _____

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed:

☐ **HIV/AIDS*** ☐ **Mental/Behavioral Health Conditions** ☐ **Drug/Alcohol Abuse/Treatment**

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: **Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, I must be provided with a copy. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that DCMC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.** **Right to Withdraw This Authorization –** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Health Information Management Department. I am aware that my withdrawal will not be effective until received by the organization and will not be effective regarding the uses and/or disclosures of my health information that the organization has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. ****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.** **EXPIRATION DATE:** This authorization is good for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REPRESENTATIVE: _____ **DATE**: _____

IF SIGNED BY LEGAL REPRESENTATIVE – STATE RELATIONSHIP: _____

WITNESS SIGNATURE (IF REQUIRED): _____

TO BE COMPLETED BY STAFF MEMBER PROCESSING REQUEST		
Faxed By:	**Date:**	**DCMC Provider:**