

Patient Name

DOB:

MR #

SwedishAmerican – A Division of UW Health  
(University of Wisconsin Hospitals and Clinics Authority)  
**AUTHORIZATION FOR DISCLOSURE OF  
HEALTH INFORMATION**

Index to Auth - PHI

**1. PATIENT INFORMATION: Please print clearly. All information must be provided.**

Full Legal Name: \_\_\_\_\_  
(First) (Last) (Middle Initial)

Current Address: \_\_\_\_\_  
(Street) (City) (Zip)

Telephone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2. I HEREBY AUTHORIZE AND REQUEST (Please check only one location per authorization):**

- SwedishAmerican Hospital  Other (Name of facility/person and address): \_\_\_\_\_
- SwedishAmerican Medical Center-Belvidere \_\_\_\_\_
- SwedishAmerican Home Care \_\_\_\_\_
- SwedishAmerican Medical Group (SAMG):  
(specify clinic location) \_\_\_\_\_

**3. TO RELEASE, USE AND/OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:**

- Abstract of above only (includes dictated reports and diagnostic test results such as lab results and x-ray reports)
- Entire medical record (includes abstract and nursing notes, progress notes, physician orders, etc.)
- Medical imaging (Radiology) films (x-rays, CT, MRI, ultrasound, cardiovascular, etc.)
- Other (specify) \_\_\_\_\_

**RELATING TO THE FOLLOWING TREATMENT OR TIME PERIOD:**

From \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

**4. THE INFORMATION MAY BE RELEASED TO:**

(Name of facility/person and address) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. THE PURPOSE(S) OR NEED FOR THIS DISCLOSURE IS:**

- Medical Care  Insurance Purposes  At the request of the patient
- Other: \_\_\_\_\_

**6. FORMAT: Please check only one box. If format is not selected, records will be in paper format.**

- Paper
- Secure electronic access (Internet access and valid email address required)  
Email address: \_\_\_\_\_  
Select a PIN: \_\_\_\_\_  
(up to 10 digits – if not chosen, date of birth will be used)

**7. EXPIRATION: This authorization will expire one year from date of authorization, unless otherwise revoked by patient.**

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**8. FOR CLINIC USE ONLY:**

If transfer is due to patient discontinuing services of physician/clinic:

- Insurance Requirement                       Physician Availability
- Dissatisfaction                                       Relocation                                       Other \_\_\_\_\_

**9. PLEASE READ THE FOLLOWING CAREFULLY:**

*I understand* that I may revoke this Authorization in writing at any time except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, SwedishAmerican Health System, and 1401 East State Street, Rockford, Illinois, 61104

*I understand* the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.

*I understand* that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information.

*I understand* that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

*I understand* that I may refuse to sign this Authorization and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

Signature of Patient or Legal Representative <i>(Patients ages 12-17 may be required to sign and date with co-signature of parent/legal guardian)</i>	Relationship to Patient	Date
Co-Signature	Relationship to Patient	Date
Signature of Witness		Date