HAKSHA
HEALTHCARE S.C

333 Bishops Way • Brookfield, WI 53005-6226
PH: (855) 942-5742 FX: (877) 942-5742
Email: Hakshahealth@gmail.com

AUTHORIZATION TO USE OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		**SS#**	
PATIENT ADDRESS		**DOB:**	

TO: (Name, Address, Phone of **Recipient** of Records) (or as noted office location above)			
Name	HAKSHA HEALTHCARE S.C.	Phone	855-242-5742
Address	333 BISHOPS WAY SUITE 125	Fax	262-439-8095/877-942-5742
City/State Zip	BROOKFIELD WI		53005-6226

RECORDS FROM (Who is **Releasing** the Records):					
Name		Phone			
Address		Fax			
City/State Zip		State		Zip	

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, If Such Information and/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	All Office Notes and Reports	☐	Most recent one year history	☐	Most recent three-year history
☐	Rx History	☐	Transcribed hospital reports	☐	Laboratory reports
☐	Billing Statements	☐	Diagnostic Reports	☐	Diagnostic Films
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe:_____

_____ By initialing here I authorize the above recipient of my health information to discuss my health information with my attorney, or a governmental agency listed here: _____.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations in accordance with Wisconsin State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from redisclosing HIIV-related, alcohol or drug treatment without my authorization unless permitted to do so under federal or state law. I understand I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the Wisconsin State Division of Human Rights at (608) 266-5525. or the Wisconsin Commission of Human Rights at (608) 266-5525. These agencies are responsible for protecting my rights.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so and this authorization does not authorize you to discuss my health information or medical care with anyone other than the entity, attorney or governmental agency specified in items above.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date)_____.

Patient Name (Print):	Legal Guardian (Print):
Patient or Legal Guardian Signature:	Date:

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STANDING AUTHORIZATION FOR DISCLOSURE OF INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the use or disclosure of protected health information (PHI) other than treatment, payment or healthcare operations (TPO). Others that are permitted to receive disclosure of information by law include: Judicial proceedings, coroners, medical examiners, research purposes, law enforcement, worker's compensation and other areas so designated by law.

Release or disclosure of information to family members, friends, clergy or others involved in a patient's care is NOT included in the General Rule and require specific authorization for disclosure of information.

If you would like us to share your PHI with family members or others, please fill in the information below for each individual, designate if unrestricted or limited release of information and date and initial each authorization. Please note that ABSOLUTELY NO INFORMATION WILL BE DISCLOSED to spouses, children, other family members, care givers or friends if not authorized below. You may rescind or change any authorization by a written request at any time.

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis, records, reports (including treatment, payment and health care operations):

Name:	Relation:	Phone;	☐ All Access ☐Appointments ☐Test results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Test results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Test results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Test results

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name:	Relation:	Phone:
Name:	Relation:	Phone:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home***. **(Confidential Communications):**

4. Print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information ***if other than your home.***

Phone: _____ ***Email:*** _____

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or Voice Mail?
☐ YES ☐ NO

I understand the Privacy Protection Act and have been offered a copy of the Notice of Privacy Policies and do hereby authorize Haksha Healthcare S.C. to disclose as I have identified above.

Patient Name:	**Date:**
Patient Signature:	
Legal Guardian/Representative Name:	**Legal Rep Signature:**