SHERIFF DAVID J. MAHONEY

Dane County Sheriff's Office

Authorization for Release of Health Information

Name: (print) DOB: Name #:

I authorize Dane County Sheriff's Office to release the following protected health information to:

- ☐ Self
- ☐ Legal Representative
- ☐ Family Member
- ☐ Medical Professional

Name: _____

Address: _____

_____

Phone: _____

I authorize the use or disclosure of specific health information as described below for the purpose of:

- ☐ Patient's request
- ☐ Continuity of care
- ☐ Legal investigation
- ☐ Other: _____

Information to be released:

- ☐ Entire medical record (includes physician's orders, progress notes, history and physical, medical requests, flow sheets, labs, etc) ☐ all dates ☐ from _____ to _____
- ☐ Most recent booking
- ☐ History and Physical
- ☐ Lab results (includes blood draws, x-rays, EKG, TB results)
- ☐ Medication Administration Record (MAR)

- Dane County Sheriff's Office cannot release 3rd party information, please send any request for outside records (including hospital discharge instructions) to that provider.

I understand that the following health information will only be disclosed if **checked & initialed**.

- ☐ _____ HIV/AIDS related treatment (including lab results)
- ☐ _____ Mental Health ☐ all dates ☐ from _____ to _____
- ☐ _____ Dental Records

- If no dates of service are provided, only the most recent booking (or last calendar year, whichever is less) will be released.
- I understand that I may revoke this authorization at any time, provided I do so in writing to County Records at Dane County Sheriff's Office, except to the extent that the records have already been released.
- Unless revoked earlier, this authorization will expire 12 months from the date of signing or until _____, whichever date occurs first.
- I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal HIPAA privacy regulations, the information described above may be disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

_____ Signature

_____ Date

_____ Witness Signature

_____ Date

Mail to: Dane County Sheriff Records 2nd Floor, 115 W. Doty St., Madison, WI 53703
Fax to: Records 608.284-6156