HOW TO COMPLETE ASCENSION WISCONSIN AUTHORIZATION FOR DISCLOSURE OF PROTECTED INFORMATION FORM

1. **Patient Information:**

   - ★ **Print Patient Name (including any previous names)**
   - ★ **Date of Birth**
   - ★ **Address, City, State, Zip Code**
   - ★ **Phone Number**
   - ★ **Email Address**

2. **Release Health Information FROM:**

   - ★ **Name of Healthcare Facility or Provider Name**
   - ★ **Address, City, State, Zip Code**

3. **Release of Health Information TO:**

   - ★ **Name**
   - ★ **Address, City, State, Zip Code**
   - ★ **Fax Number**

4. **Information to be Released:**

   - ★ **Check type of information needed to be released**
   - ★ **Include specific dates service was provided**

5. **Purpose of Disclosure: Check reason records need to be released**

6. **Date Needed by and Delivery Method:**

   - ★ **Indicate date records are needed by**
   - ★ **Mail, fax, Other**

7. **Check if you do not want sensitive records released: HIV/AID, Substance Abuse, Behavioral Health**

8. **Patient Rights with respect to this Authorization**

   - ★ **Read Patient Rights**
   - ★ **Authorization expires in 1 year unless otherwise noted at "X"**
   - ★ **Patient Signature, date and time of signature at "Xs"**
   - ★ **If signed by someone other than patient, include why and who you are in relation to patient**

   ***** Form is not valid until signed and dated. *****