PillarHealth YOUR LOCAL HEALTH CENTER

KCHC KENOSHA COMMUNITY HEALTH CENTER, INC.

Authorization for Disclosure of Protected Health Information (PHI) Internal Request

Patient Information

Patient Name: ______________________ Date of Birth: __________

Address: ______________ City: __________ State: ________ Zip: ______

Email Address: ______________________ Phone: __________

I hereby authorize the release of the protected health information for the above-named individual as follows:

PHI Requested from Pillar Health / KCHC

- ☐ 4536 22nd Avenue, Kenosha, WI 53140
- ☐ 6226 14th Ave., Kenosha, WI 53141
- ☐ 903S. 2nd St., Silver Lake, WI 53170
- ☐ 4006 Washington Road, Kenosha, WI 53144

Contact Information for Medical Records / ROI

Ph. (262) 771-1700, Option 3 / Fax (262) 657-9146

PHI Given and/or Sent To:

Name: ______________________

Organization: ______________________

Address: ______________________

City: ______________________

State, Zip: ______________________

Phone: ______________________

Fax: ______________________

Dates: Include from ______________ to ______________

If dates are not specified, we will only release the last 2 years of records.

Health Record Type (Select all that apply)**:** ☐ Medical Record ☐ Dental Record ☐ Behavioral Health Record

Select which part(s) of the Health Record that need to be released:

☐ Progress Notes	☐ History & Physical	☐ Diagnostic Tests
☐ Prescription / Medication List	☐ X-Rays	☐ Laboratory Results
☐ Consultation Notes	☐ Radiology	☐ Pathology Reports
☐ Immunization Records	☐ Correspondence	☐ Other: __________

Please note that information subject to disclosure may include information related to the testing, diagnosis or treatment of mental health, alcohol and drug abuse, HIV/AIDS and genetics. testing. If desired, identify any information to be limited or restricted:

☐ Alcohol & Drug Abuse ☐ HIV / AIDS ☐ Genetics Testing ☐ Mental Health (Excluding Psychotherapy notes)

☐ Other ______________________

For the purposes of:

☐ Continued Medical Care	☐ Financial Assistance	☐ Employment, Disability or Vocational Rehab
☐ School or Daycare	☐ Changing Provider	☐ Insurance Claim or Application
☐ Legal Counsel	☐ Other: __________	

This authorization will expire one (1) year from date of signature, unless revoked in writing. No treatment, payment, enrollment, or eligibility for benefits may be conditioned on signing this authorization. When disclosed to the authorized recipient, this information may be subject to re-disclosure and may no longer be protected by Federal or State law. If the patient is unable to sign, the person signing this authorization will be required to show proof of relationship to patient or other authority allowing him/her to authorize the disclosure of the patient's health information.

Signature: ______________________ Date: __________

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other: ______________