COMMUNITY CARE PROGRAM
Authorization for Representation and Release of Information

AUTHORIZATION FOR REPRESENTATION

I, the undersigned, hereby authorize Stoughton Hospital and its Community Care employees to discuss the specifics of my medical and financial file in their efforts to research financial and medical resources on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any person, governmental agency, corporation or other medical or financial entity to release to Stoughton Hospital's Community Care staff any information within his/her/its possession pertaining to my case.

Medical Information

This authorization includes the release to Stoughton Hospital of all clinic and medical information, electrocardiograms, immunizations and allergy records, lab, x-rays and eye reports.

I also give special permission in compliance with Wisconsin Statutes for the release to Stoughton Hospital of mental health, alcohol, HIV (Aids), drug abuse and developmental disability information pertaining to my file.

Financial Information

This authorization includes the release to Stoughton Hospital of any financial statements, business reports, payroll or benefit information from my past or present employers, banks or other financial institutions or government agencies.

Other related information

Finally, I authorize the release to Stoughton Hospital of any other related information, including psychological, social, vocational, rehabilitative or educational reports, assessments or evaluations.

I authorize the release of the above information for dates up to and including the date of my signature.

I understand written notification is required by me to revoke this authorization. I also understand that a photocopy of this authorization has the same effect as the original.

____ ___________________________
Signature of Patient Giving Authorization Date

If signed by person other than patient, state relationship and authority to do so.
Patient is ____ minor ____ incompetent ____disabled
Authority ____ legal ____ legal guardian

Please return this to the Community Care Representative along with your application for Community Care.

Form No. 6039