Ascension Employer Solutions

Ascension Wisconsin Employer Solutions

Authorization for Disclosure of Protected Information

I acknowledge receipt of the Ascension Wisconsin's Notice of Privacy Practices that outlines the use of my health information. In addition to the uses outlined there, I hereby authorize Ascension Wisconsin to release my health information to the following parties outlined below:

Information to be Released to: My employer's Broker, or their third-party vendor, for analysis of employee health and wellness trends

Information to be Released includes my medical record maintained by: Ascension Wisconsin Employer Solutions

The medical record could include, but is not limited to, clinic office notes, lab/imaging reports, immunization records and billing information.

Please Check If You DO NOT Want the Following Information Disclosed: ☐ HIV/AIDS (including test results)

For the following date(s) of service: _____ to ONGOING

Your Rights with Respect to this Authorization

I understand that:

- "Ascension Wisconsin" refers to all healthcare organizations wholly owned, controlled and/or managed indirectly or directly
- I have a right to inspect or receive a copy of any health information used or disclosed.
- I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to [insert where they should send revocation]. I understand that my revocation will not apply to information that has already been released in response to this authorization.
- If a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization is voluntary. Ascension Wisconsin will not condition your treatment on this authorization.

This authorization expires 365 days from the date it is signed by the patient unless other noted _____

_____.

Signature of Patient or Authorized Representative	Date	Time	Date of Birth

If you are signing as a parent of the minor patient listed above, you are declaring that your parental rights have not been terminated.

If signed by other than the patient, indicate relationship or authority: Patient is: ☐ Minor ☐ Incompetent ☐ Deceased

I am: ☐ Parent ☐ Legal Guardian ☐ Health Care Agent of Incapacitated Patient ☐ Next of Kin of Deceased ☐ Executor of Estate

If unable to sign, give reason: _____

Signature of Witness (when applicable)	Date	Time