SHERIFF KALVIN D. BARRETT

DANE COUNTY SHERIFF'S OFFICE

Authorization for Release of Health Information

Name: Date of Birth:

(Please Print Name)

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

- ☐ Self — Name:
- ☐ Legal Representative — Address:
- ☐ Family Member — Email:
- ☐ Medical Professional — Phone:

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

- ☐ Patients Request
- ☐ Continuity of Care
- ☐ Legal Investigation
- ☐ Other:_____

Information to be released: (please select only one of the following options)

- ☐ Dates from _____ to_____ **OR**
- ☐ All Dates (incl. past & present bookings)
- ☐ Most Recent Booking

Please check the following box(es) of the records to be released per this request:

- ☐ ENTIRE MEDICAL RECORD
- ☐ History and Physical Exam
- ☐ Medication Administration Report
- ☐ Chronic Care
- ☐ Progress Notes
- ☐ Medical Requests Slips
- ☐ Lab Results (incl. blood draw, x-ray reports, EKG, TB results)
- ☐ Emergency Reports
- ☐ Nursing Pathways
- ☐ Provider Orders
- ☐ Other specify :_____

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

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

If left unchecked, the following records will not be disclosed

HIV/AIDS related treatment	☐ Yes	☐ No	Dates:_____
Mental Health	☐ Yes	☐ No	Dates:_____
Dental Records	☐ Yes	☐ No	Dates:_____

By signing this authorization form, I understand that:

- If no dates of service are provided, only the most recent booking (or last calendar year, whichever is less) will be released.
- 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.
- 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 regulation, 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 at 115 W Doty St, Madison WI 53703

Fax to: Records 608-284-6156