MEDICAL EXAMINER

500 Rolfs Avenue, Room 1130
West Bend, WI 53090-2603
(262) 335-4460
FAX (262) 335-7715

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Person/Subject of Record: _____ Date of birth: _____

I hereby authorize the Medical Examiner of Washington County to release to:

Agency/Individual: _____

Address: _____

_____

Telephone: _____

Specific information to be released from the Medical Examiner of Washington County record:

_____

_____

Purpose of the Disclosure:

☐ At the request of the individual
☐ For legal investigation
☐ Other: _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and the health information might be re-disclosed without my permission.

I understand that I have the right to:

- Receive a copy of this authorization.
- Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- Revoke this authorization at any time by giving written notice of my revocation to the Agency/Individual listed above (the Disclosing Agency). I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before receiving my written notice of revocation.
- Right to receive a copy of records to be released: I have the right to inspect and copy the health information to be used or disclosed pursuant to this authorization.

This authorization will remain in effect until the following date(s): _____, or one (1) year.

Signature _____ Date: _____

Print Name _____

Relationship to the person:

☐ Spouse
☐ Domestic Partner
☐ Personal Representative
☐ Adult member of the deceased's immediate family