861 Critter Court
Onalaska, WI 54650
Phone: 608.783.2292
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AUTHORIZATION TO EXCHANGE INFORMATION (HIPAA)

1. Identifying Information
Applicant Name: ____ DOB: ___________________

2. Duration
The duration of this authorization shall be from application date listed below to date of discharge from facility, or denial of application, whichever comes first.

3. Type of Information
This document authorizes the entities listed below to exchange the following information:

- Medical Status and Information
- Mental Health and Substance Use Information
- Care and Service Information
- Financial and Billing Information

4. Covered Entities/Individuals
I authorize my primary care provider____, and any other doctor, hospital, nursing home, assisted living facility, pharmacy, home health agency or other medical provider from whom I have received services, to exchange (disclose and receive) information with SpringBrook Community of Onalaska for the purposes of admission evaluation and/or on-going care coordination.

In addition, the following individuals are also authorized to exchange (disclose and receive) information related to my admission and care at SpringBrook:

____ ____
Name Relationship Name Relationship

____ ____
Name Relationship Name Relationship

5. Authorization
I authorize exchange (disclosure and receipt) of all confidential and/or protected health information as outlined above. In accordance with HIPAA Act 45, CFR parts 160 & 164, understand I may change this authorization, in writing, at any time. Revocation of this document would require an immediate end to any services that SpringBrook may be providing, including facility residency.

____
Signature of Applicant Date

____
Signature of Activated Health Care Power of Attorney Date