



Return to:
SACS Inc.
P.O. Box 130
Sparta, WI 54656

Date _____

Fuel _____ Groceries _____ Medical Costs _____

Transportation _____ Medication _____ Other _____

NAME _____ PHONE _____

ADDRESS _____

DIAGNOSIS _____

PHYSICIAN _____

REQUEST FOR ASSISTANCE _____

BOARD ACTION ON REQUEST

Recipient Signature

Board Member Signature

NAME OF PATIENT: _____ BIRTH DATE: _____

I, hereby consent to and authorize Franciscan Skemp Healthcare-Sparta Campus Clinic, of Sparta, Wisconsin (or name of other health care facility _____) to disclose to:

NAME OF PERSON OR FACILITY: _____

ADDRESS: _____

Information from my health care record relating to my identify, prognosis or treatment.

THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED IS AS LISTED BELOW

Medical history or diagnostic and therapeutic information; which may include information regarding mental health, developmental disability and alcohol or drug abuse.

Specify information of particular interest _____

Excluding: _____

THE PURPOSE OR NEED FOR THIS DISCLOSURE IS: (CHECK THOSE THAT APPLY)

_____ Medical Care

_____ Insurance Claim

_____ Insurance Application

_____ Other (specify) _____

I understand that I have a right to inspect and receive a copy of the material that is disclosed as provided by Wisconsin Administrative Code.

I understand that this consent is revokable. However, information may have been release before receipt of my written notice revoking this consent. Unless revoked, this consent will expire 90 days from the date below. As a patient I have the right to access my treatment records during and after discharge. Review of records may be done by appointment during regular business hours, Monday through Friday 8 am to 4 pm and copies of records may be obtained with reasonable notice and payment of copying fee.

Patient Signature

Date

Time

Parent/Guardian/Authorized Representative

Date

Time

Relationship to Patient

Witness

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION