**RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM**

Wisconsin Department of Transportation

MV3510 4/2019

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Name | Driver License Number   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  | – |  |  |  |  | – |  |  |  |  | – |  |  | | 1 | 2 | 3 | 4 |  | 5 | 6 | 7 | 8 |  | 9 | 10 | 11 | 12 |  | 13 | 14 | |
| Street Address | |
| City, State, ZIP Code | |

I,       , understand that the Wisconsin Department of

Transportation may possess medical records and medical information about me that federal law protects from sharing with others without my consent, including “protected health information” protected by 45 Code of Federal Regulations 164. I hereby grant permission to the Wisconsin Department of Transportation to disclose any and all of my protected health information, including any psychotherapy notes as defined in 45 Code of Federal Regulation 164.501, in its records to

*(name of entity or individual to receive the information)*

at the request of the entity or individual.

The purpose of this authorization is to fulfill my request to have the Wisconsin Department of Transportation **release** my medical records to the above-named entity or individual.

I further authorize the Wisconsin Department of Transportation to **discuss** any of my medical records with the entity or individual named above by initialing here:       . I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorizing this disclosure. This authorization shall expire one year from the date that this document is signed, as shown below. I understand that I may revoke this authorization at any time by sending written notification to the Medical Review Unit at P.O. Box 7918, Madison WI 53707. The notice will not apply to actions taken by the Wisconsin Department of Transportation prior to the date it receives the notice.

I understand that information disclosed under this authorization might be redisclosed by the recipient, and that this redisclosure may no longer be protected by federal or state law.

Signature of Participant or Personal Representative

Date

Printed Name of Participant or Personal Representative

Description of Personal Representative’s Authority