I authorize the person(s) listed below to discuss my medical condition(s) or treatment(s) with medical providers involved in my care. The following information may be included in these discussions:

- ☐ Financial Information
- ☐ HIV/AIDS
- ☐ Mental Health
- ☐ Substance/Alcohol Abuse
- ☐ Family Planning (applies only to minors age 15 and older whose parent / legal representative is responsible for payment, or services were provided by family planning agencies receiving state/federal family planning funding)

(Unless checked no information related to the above will be included in any discussions.)

I understand that this authorization will not allow these individuals to obtain copies of my medical record and that this would require a separate authorization to be completed by me.

Person(s) Authorized: _____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

This release will remain in effect unless revoked by me in writing.

Patient Name: _____ Date of Birth: _____

(Please Print)

Signature: _____ Date: _____

DISCLAIMER: This document will automatically become null and void upon the death of the above-named patient and will not be honored by SCH.

ST. CROIX HEALTH
235 State Street St. Croix Falls, WI 54024

CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION WITH HEALTHCARE PROVIDERS & STAFF

H:SCRMC/FORMS/HIS/HIS 87 for the duration of 2026