# LAKE DELTON POLICE DEPARTMENT

35 Miller Drive, PO Box 510, Lake Delton WI 53940
Office 608-254-7571 ▪ Dispatch 608-254-8331 ▪ Fax 608-254-4651
Email: ldpd@lakedeltonpd.org

## MEDICAL RECORDS RELEASE AUTHORIZATION

Name & Address of Medical Facility:

_____ Date: _____

_____ LDPD Case #: _____

_____

You are hereby authorized to release to the Chief of Police of the Village of Lake Delton Wisconsin, or his designee, any and all **certified** medical records held in your custody pertaining to medical treatment provided by you to:

Patient Name: _____ Date of Birth: _____

Address: _____

on the date(s) of _____

The records will be used for the purpose of aiding in a criminal prosecution and/or investigation of offenses within the Village of Lake Delton.

This authorization for release of medical records is valid for a period of one (1) year from the date this form is signed.

I understand that the medical provider covered by this authorization may not condition treatment, payment, enrollment or eligibility of benefits on whether or not I sign this authorization.

This release may include psychiatric, development disability, alcohol or drug abuse information, AIDS test results or AIDS related diseases as specified: _____

I understand the Lake Delton Police Department is not a health care plan or provider and that after I authorize release, the information may no longer be protected by the federal or state privacy standards and my health information may be re-disclosed for use in a legal proceeding without obtaining further authorization.

I understand that I may revoke this consent, in writing at the Lake Delton Police Department, except for information already released as a result of this authorization.

I hereby authorize and request release of my medical records, assessment/treatment records and/or specifications listed above.

X_____ _____
Signature of Patient Date

If signed by a person other than the patient, state the relationship and authority to do so:

Relationship: _____

Patient is: ( ) Minor ( ) Incompetent/Incapacitated ( ) Deceased

Legal Authority: ( ) Legal Guardian ( ) Parent of Minor ( ) Spouse of Deceased ( ) Personal Representative of Deceased
( ) Health Care Agent_____ ( ) Other