

# LAKE DELTON POLICE DEPARTMENT

50 Wisconsin Dells Pkwy S, PO Box 510, Lake Delton WI 53940  
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Email: ldpd@lakedeltonpd.org

## MEDICAL RECORDS RELEASE AUTHORIZATION

Name & Address of Medical Facility:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

You are hereby authorized to release to the Chief of Police of the Village of Lake Delton Wisconsin, or his designee, any and all 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