DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
F-82002 (07/08)

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS

(Private Pay Patients Only)

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) State and federal law directs government agencies to make sure that doctors, nurses, hospitals and other health care providers give health care of good quality in a safe setting and protect patient rights.

2) To make sure that health care services meet the basic legal requirements, state and federal agencies may need to review patient health care records. These records tell agencies how patients have been treated and can be very important during any investigation of alleged poor care, patient abuse, fraud, or patient rights violations. These agencies have a legal duty to keep the records they review confidential.

3) State law says that a private pay patient except a nursing home resident may choose to keep state and federal agencies from reviewing his or her health care records; this may be done by signing the Denial or Government Access statement below. Please feel free to discuss this matter with family, friends, or an attorney.

4) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.

5) If you sign this form and later change your mind and decide to let state and federal agencies review your health care records, you may cancel the Denial of Government Access statement below at any time by signing the Cancellation Statement on the back of your copy of this form or your own cancellation statement and giving it to your health care provider.

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS (Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep state and federal agencies from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing the statement on the back of this copy or my own cancellation statement. (S. 146.82(2)(a)5., Stats.)

SIGNATURE – Patient (or Legal Guardian)	Date Signed

(Note: If you are in a hospital, a copy of this form will be sent to your private physician once it is signed.)

CANCELLATION STATEMENT

I hereby cancel the Denial of Government Access statement I signed on the front of this form. I now wish to let state and federal agencies review my health care records.

SIGNATURE – Patient (or Legal Guardian)	Date Signed