**DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**
F-82003 (07/08)

# DENIAL OF RESEARCHER 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) In order to perform studies of health care, researchers affiliated with your health care provider may wish to review your health care records. These researches have a legal duty to keep your identity confidential and to make sure that information from your health care records is not given to anyone who is not connected with the research.

2) State law says that a private pay patient may choose to keep researchers from reviewing his or her health care records; this may be done by signing the Denial of Researcher Access statement below. Please feel free to discuss this matter with family, friends, or an attorney.

3) 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.

4) If you sign this form and later change your mind and decide to let researchers review your health care records, you may cancel the Denial of Researcher Access statement below at any time by signing a written cancellation statement and giving it to your health care provider.

**DENIAL OF RESEARCHER 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 researchers 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 a written cancellation statement. (S. 146.82(2)(a)6., Stats.)

| **SIGNATURE** – Patient (or Legal Guardian) | Date Signed |
|---|---|
| | |

**DISTRIBUTION:** Original – Patient Copy – Health Care Provider

# CANCELLATION STATEMENT

**I hereby cancel the Denial of Researchers 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 |
| --- | --- |
| | |