Health Department
1000 Lake View Drive, Suite 100
Wausau, WI 54403-6797

Tel/TDD: 715-261-1900
Fax: 715-261-1901
www.co.marathon.wi.us

Request and Authorization for Release of Tuberculosis (TB) Records

I hereby request and authorize Marathon County Health Department to release the following Tuberculosis records to me.

☐ TB Blood Test Results
☐ TB Skin Test Results
  ☐If the results are positive, please also release TB Treatment Information
☐ TB Treatment Information – this includes plan of care, nursing notes, medication list, and letters

Name on Record: _____
  Other Name(s) record(s) may be under: _____
Date of Birth: _____
Relationship of person requesting records: ☐ Self ☐ Parent/Guardian
When did Testing or Treatment Occur (if known): _____
Best phone number to contact you with questions regarding this request: _____

I would like the records
  ☐ Mailed to me at: _____
  ☐ Call me when records are ready to be picked up
    Phone number: _____

This authorization for release is effective for 30 calendar days and only for Tuberculosis (TB) records for medical care provided by the Marathon County Health Department.

I hereby certify under pains and penalty of perjury that I am the person named above for whom records are being requested. I understand the records requested will be available for pick up or mailed out via US Postal Service within 3 business days.

I understand that submitting this form on-line may not be secure and it is possible that this confidential message may be intercepted and seen by people other than Marathon County Health Department employees.

Signature: _____ Date: _____

For Office Use Only: ☐No Records Found – Letter Sent - Date/Initial: _____

☐Records Retrieved - Sent – Date/Initial: _____