Marshfield Clinic Health System

Clear Form

Patient Name:	MRN:	DOB:	Sex:

Sharing of Information Authorization

1. Patient Information

Name:	Date of Birth	
Address	Phone #	
City	State	ZIP

2. Health Care Facility who has the information you want released

☐ **Marshfield Clinic Health System - All Locations (**excludes all Family Health Center Locations)**

3. Who you want the information shared with

Please list the name, relationship & phone # for individuals you want information shared with:

Name: _____ Relation _____ Phone #: _____

Name: _____ Relation _____ Phone #: _____

Name: _____ Relation _____ Phone #: _____

Please list the name of organization/facility you want information shared with:

ORGANIZATION/FACILITY _____

Address _____ City _____ State _____ ZIP _____

Contact Person _____ Phone # _____

4. Information to be shared

☐ Medical Information including appointment verification **(excludes mental health, AODA treatment & HIV test test results)** -- may leave messages on voicemail

☐ Two way communication information ☐ Billing information (may include health information)

☐ **Specific Information:** Diagnosis: _____

Provider: _____ Date Range: _____

Records Requiring Specific Consent:

The applicable records must be checked in order to be released

- ☐ Psychological Testing
- ☐ Mental Health Treatment Notes
- ☐ AODA Treatment Notes
- ☐ Neuropsychology Notes
- ☐ HIV/AIDS Results
- ☐ Genetic Testing Results

Records Requiring Minor Consent: ***The applicable records must be checked in order to be released***

- ☐ Outpatient AODA (12+yrs)
- ☐ Inpatient AODA - Detox Only (12+yrs)
- ☐ Outpatient mental health care (14+yrs)
- ☐ Inpatient mental health care (14+yrs)
- ☐ Neuropsychology notes (14+yrs)
- ☐ Rape or sexual assault/abuse (12+yrs)
- ☐ Sexually transmitted disease (17+yrs)
- ☐ Pregnancy test (17 yrs or younger)
- ☐ Birth control pills (17 yrs or younger)
- ☐ Pregnancy-related care or care of newborn (17 yrs or younger)
- ☐ HIV/AIDS test results (14+yrs)

_____ _____

Patient signature Date/Time

Additional Permissions Granted:

☐ Access to "My Marshfield Clinic" portal - incudes my Marshfield medical record number (MRN) for access

☐ Relative who is a physician at MCHS may access my electronic medical record (*i.e., spouse, child, etc*)

Sharing of Information Authorization (Continued)

Patient Name:	MRN:	DOB:	Sex:

5. Expiration

This authorization will remain in effect:

- ☐ Until you cancel this authorization in writing
- ☐ From the date of signature until the following date: _____
- ☐ Until the following event occurs: _____

This form will no longer be valid upon the death of the patient*

My signature authorizes the use and disclosure of the information I have selected above. I acknowledge that I have reviewed and understand this authorization form, including the notices below.

Patient Signature	Date/Time	Printed Name
Signature of Authorized Person	Date/Time	Printed name

☐ Parent of Minor ☐ Court appointed guardian/conservator - include legal documentation

Wisconsin Authorizations:

Mail Copies to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Copies to: 715-389-0564
Email Copies to: himspec@marshfieldclinic.org

Michigan Authorizations:

Mail Form to: MMC-Dickinson, 1712 S. Stephenson St, Iron Mtn, MI 49801
ATTN: Health Information Management - ROI

Fax Form to: 906-221-6992
Email Form to: medicalrecords@marshfieldclinic.org

Marquette Center, 1414 W. Fair Ave, Suite 334
Marquette, MI 49855
ATTN: Health Information Management - ROI

Fax Form to: 906-225-3919

Sharing of Information Authorization (Continued)

Patient Name:	MRN:	DOB:	Sex:

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  - research-related treatment
  - health plan enrollment or eligibility
  - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

