SANFORD HEALTH
Marshfield Clinic

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**

☐ **Sanford Health Marshfield Clinic - 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 messages on voicemail **(excludes mental health and HIV test results) -** may leave

☐ 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
- ☐ Neuropsychology Notes
- ☐ HIV/AIDS Results
- ☐ Genetic Testing Results

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

- ☐ 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 - includes My Marshfield medical record number (MRN) for access
Please call 715-387-5152 to request to have portal access activated for those authorized.

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

 © 2023 Sanford Health Marshfield Clinic

## 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 Form to:*** MCHS, 1000 North Oak Avenue, Marshfield, WI 54449

***Fax Form to:*** 715-389-0564

***Email Form to:*** himspec-mfld@sanfordhealth.org

 © 2023 Sanford Health Marshfield Clinic

## 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 or Section 550.1406 of the Michigan 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 disclosed without your authorization to persons/organizations allowed access under Wisconsin law and Michigan law. 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.

 © 2023 Sanford Health Marshfield Clinic