| Patient name | | | |
|---|---|---|---|
| MHN | DOB | Age | Gender |

**Occupational Medicine**

# Release of Information Authorization



**NOTE: This authorization will be returned and records will be delayed if all sections are not completed.**

| | | | |
|---|---|---|---|
| **Patient information** | Address | Daytime phone number | |
| | City | State | ZIP |
| **Who has the information that is to be released** | Name<br>Marshfield Clinic, Occupational Medicine Department | Phone number | |
| | Address | Fax | |
| | City | State | ZIP |
| **Whom should the information be sent to or who should be involved in the care** | Name | Phone number | |
| | Attention | Fax | |
| | Address | | |
| | City | State | ZIP |

**Medical care, medical records or other records to be disclosed per request**

Check (✓) boxes of the following information to be released

☐ **Results of pre placement exam*** (date/date range – m/d/y) _____
The types of information that may be disclosed are records, reports, documents, materials, notes, memoranda, correspondence, x-rays, lab reports.

☐ **Results of Department of Transportation exam*** (date/date range – m/d/y) _____
The types of information that may be disclosed are records, reports, documents, materials, notes, memoranda, correspondence, x-rays, lab reports.

☐ **Results of occupational health surveillance exam or test for respirator usage***
(date/date range – m/d/y) _____ The types of information that may be disclosed are records, reports, documents, materials, notes, memoranda, correspondence, x-rays, lab reports.

☐ **Results of occupational hazardous material exposure exam***
(date/date range – m/d/y) _____ The types of information that may be disclosed are records, reports, documents, materials, notes, memoranda, correspondence, x-rays, lab reports.

☐ **Results of breath alcohol testing*** (date/date range – m/d/y) _____
The types of information that may be disclosed are records, reports, documents, materials, notes, memoranda, correspondence, x-rays, lab reports.

☐ **All office notes and audiograms related to workplace OSHA hearing conservation program***
(date/date range – m/d/y) _____

☐ **Other*** (date/date range – m/d/y) _____

**The results or other information you authorize to be disclosed may include information previously collected about you and contained in the Marshfield Clinic medical record.*

**Reason for the release**

I understand that the purpose or need for this disclosure is for the above named company's use in:

☐ Monitoring of my occupational health

☐ Assuring compliance with occupational health and safety regulations and/or company policies

☐ Making a determination of whether to hire me or place me in a specific employment position

  

**Occupational Medicine**

# Release of Information Authorization (Continued)



| Patient name | MHN | DOB | Age | Gender |
|---|---|---|---|---|
| | | | | |

| **Expiration** | This authorization will remain in effect until the releases identified above are completed. |
|---|---|

**By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form, including the notices below.**

| Patient signature (Patient's legal representative) | (Relationship) | _____/_____/_____ Signature date (m/d/y) | Phone number |
|---|---|---|---|
| | | | |

**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, 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.

  