

Patient name			
MHN	DOB	Age	Gender

Release or Share

Release of Information Authorization

For the purpose of sharing information with a family member complete sections A, B, C, E, J & K.

For the purpose of releasing information complete sections: A, B, C, D, F, G (minors only), H, I, J & K.

A Patient	Previous last name (if any)		Daytime phone number	
	Address			
	City		State	ZIP
B Who has the information that is to be released	<input type="checkbox"/> Marshfield Clinic Health System, Inc./Family Health Center, 1000 N. Oak Ave., Marshfield, WI Phone: 1-800-782-8581, ext. 7-5687 <input type="checkbox"/> _____			
	Address _____			
	City _____		State _____	ZIP _____
	Phone _____		Fax _____	
C To whom the information should be released	Name		Phone number	
	Attention		Fax	
	Address			
	City		State	ZIP
D Medical records or other records to be disclosed Check (✓) box(es) of the records to be released per this request (if minor is signing this authorization, see section titled "Special medical record release by minor")	Medical records: <input type="checkbox"/> Consults <input type="checkbox"/> Correspondence <input type="checkbox"/> X-ray reports <small>(See Section F)</small>			
	<input type="checkbox"/> Medical history and notes <input type="checkbox"/> Dental <input type="checkbox"/> Surgical reports <input type="checkbox"/> HIV/AIDS test results			
	<input type="checkbox"/> Laboratory/Pathology reports <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospital records <input type="checkbox"/> Forms/Opinion reports			
	<input type="checkbox"/> Billing/Financial records <input type="checkbox"/> Immunizations <input type="checkbox"/> School records <input type="checkbox"/> Third-party records			
E Medical or other records to be shared with relatives or other persons Check (✓) box(es) to indicate the information you want shared	<input type="checkbox"/> Medical treatment information can be disclosed: written or verbal communication, voice mail, appointment verification (excluding mental health treatment, AODA treatment, HIV test results)			
	Check individual items below that can be shared:			
	<input type="checkbox"/> Mental health treatment notes <input type="checkbox"/> Dental <input type="checkbox"/> Research			
	<input type="checkbox"/> Alcohol and other drug therapy <input type="checkbox"/> My Marshfield Clinic – online health management			
<input type="checkbox"/> Neuropsychology notes <input type="checkbox"/> Obtain copies or authorize release of my medical records (which may include authorizing release of medical records to other facilities on my behalf)				
<input type="checkbox"/> My medical history number				
<input type="checkbox"/> Treatment of HIV/AIDS, including test results				
<input type="checkbox"/> Billing information about my account which may include health information				
<input type="checkbox"/> Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR)				
<input type="checkbox"/> Specific information as follows: Diagnosis _____				
Provider _____		Date range _____		

Release or Share

Release of Information Authorization (Continued)

Patient name _____	MHN _____	DOB _____	Age _____	Gender _____
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F Radiology films, pathology slides, or photographs to be disclosed	<p>Check (✓) boxes below for the films, slides or photographs to be released per this request:</p> <p><input type="checkbox"/> Original x-ray of _____ <input type="checkbox"/> Mailed date (m/d/y) ____ / ____ / ____</p> <p><input type="checkbox"/> Photographs _____ (return loaned films/slides within 30 days)</p> <p style="padding-left: 20px;">(define type _____) <input type="checkbox"/> Pick up date (m/d/y) ____ / ____ / ____</p> <p><input type="checkbox"/> Pathology slides of _____ By _____</p>
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G Special medical record release by minor	<p>I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or any one else.</p> <p>Check (✓) boxes of medical records to be disclosed:</p> <p><input type="checkbox"/> Outpatient alcohol or other drug dependency care (12 years or older) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> Rape or sexual assault/abuse (12 years or older) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> Outpatient mental health care (14 years or older)</p> <p><input type="checkbox"/> Inpatient mental health care (14 years or older)</p> <p><input type="checkbox"/> Neuropsychology notes (14 years or older) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> HIV/AIDS test results (14 years or older)</p> <p><input type="checkbox"/> Sexually transmitted disease (17 years or younger)</p> <p><input type="checkbox"/> Pregnancy test (17 years or younger) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> Birth control pills or devices (17 years or younger) <i>(parent may also be required to sign below)</i></p> <p><input type="checkbox"/> Pregnancy-related care or care of newborn (17 years or younger)</p> <p><input type="checkbox"/> Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR) including but not limited to information above <i>(parent may also be required to sign below)</i></p> <p>Patient signature _____ Date (m/d/y) ____ / ____ / ____</p>
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H Method of release	<p><input type="checkbox"/> Email (use of encryption required) Email address _____</p> <p><input type="checkbox"/> Paper <input type="checkbox"/> Other, specify _____</p> <p><i>Note: Information supplied electronically is in PDF format and is encrypted.</i></p>
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I Reason for the release	<p>Check (✓) box below to indicate the reason for the release per this request:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Continuing health care needs</td> <td><input type="checkbox"/> Preemployment or medical evaluation</td> </tr> <tr> <td><input type="checkbox"/> Disability</td> <td><input type="checkbox"/> Billing, collection or payment of claims</td> </tr> <tr> <td><input type="checkbox"/> Transfer of care</td> <td><input type="checkbox"/> Post-employment testing or medical</td> </tr> <tr> <td><input type="checkbox"/> Care coordination or case management</td> <td><input type="checkbox"/> Employment determination (non-work-related illness or injury)</td> </tr> <tr> <td><input type="checkbox"/> Second opinion/referral</td> <td><input type="checkbox"/> Litigations</td> </tr> <tr> <td><input type="checkbox"/> Personal</td> <td><input type="checkbox"/> Other, specify _____</td> </tr> <tr> <td><input type="checkbox"/> Financial assistance</td> <td></td> </tr> </table>	<input type="checkbox"/> Continuing health care needs	<input type="checkbox"/> Preemployment or medical evaluation	<input type="checkbox"/> Disability	<input type="checkbox"/> Billing, collection or payment of claims	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Post-employment testing or medical	<input type="checkbox"/> Care coordination or case management	<input type="checkbox"/> Employment determination (non-work-related illness or injury)	<input type="checkbox"/> Second opinion/referral	<input type="checkbox"/> Litigations	<input type="checkbox"/> Personal	<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Financial assistance	
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<input type="checkbox"/> Personal	<input type="checkbox"/> Other, specify _____														
<input type="checkbox"/> Financial assistance															

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J

Expiration
Check (✓) box to indicate the expiration per this request

This authorization will remain in effect:

From the date this authorization is signed until the _____ day of _____, 20 _____

Until you cancel this authorization in writing.

Until the following event occurs, specify event _____

Other, specify _____

K

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 to patient) Signature date (m/d/y) Phone number

Send completed authorization to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

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

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.