Patient name			
MHN	DOB	Age	Gender

Release of Information Authorization

A Patient

Previous last name (if any) | Daytime phone number

Address

City | State | ZIP

B Who has the information that is to be released

☐ Marshfield Clinic Health System, Inc./Family Health Center, 1000 N. Oak Ave., Marshfield, WI Phone: 1-800-782-8581, ext. 7-5687

☐ _____

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:

☐ Consults ☐ Correspondence ☐ X-ray reports *(See Section E)*

☐ Medical history and notes ☐ Dental ☐ Surgical reports ☐ HIV/AIDS test results

☐ Laboratory/Pathology reports ☐ Prescriptions ☐ Hospital records ☐ Forms/Opinion reports

☐ Billing/Financial records ☐ Immunizations ☐ School records ☐ Third-party records

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☐ Other, specify _____

Mental health/alcohol & other drug abuse/neuropsychology records:

Specify facility: ☐ Marshfield Clinic Health System ☐ Family Health Center

☐ Mental health AND/OR ☐ Alcohol & other drug abuse AND/OR ☐ Neuropsychology

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☐ Other, specify _____

E Radiology films, pathology slides, or photographs to be disclosed

Check (✓) boxes below for the films, slides or photographs to be released per this request:

☐ Original x-ray of _____ ☐ Mailed date (m/d/y) _____ /_____ /_____

☐ Photographs (return loaned films/slides within 30 days)

(define type _____) ☐ Pick up date (m/d/y) _____ /_____ /_____

☐ Pathology slides of _____ By _____

F Method of release

☐ Email (use of encryption required) Email address _____

☐ Paper ☐ Other, specify _____

Note: Information supplied electronically is in PDF format and is encrypted.

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

G

Special medical record release by minor

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.

Check (✓) boxes of medical records to be disclosed:

- ☐ Outpatient alcohol or other drug dependency care (12 years or older) *(parent may also be required to sign below)*
- ☐ Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) *(parent may also be required to sign below)*
- ☐ Rape or sexual assault/abuse (12 years or older) *(parent may also be required to sign below)*
- ☐ Outpatient mental health care (14 years or older)
- ☐ Inpatient mental health care (14 years or older)
- ☐ Neuropsychology notes (14 years or older) *(parent may also be required to sign below)*
- ☐ HIV/AIDS test results (14 years or older)
- ☐ Sexually transmitted disease (17 years or younger)
- ☐ Pregnancy test (17 years or younger) *(parent may also be required to sign below)*
- ☐ Birth control pills or devices (17 years or younger) *(parent may also be required to sign below)*
- ☐ Pregnancy-related care or care of newborn (17 years or younger)
- ☐ 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 *(parent may also be required to sign below)*

Patient signature _____ Date (m/d/y) _____ /_____ /_____

H

Reason for the release

Check (✓) box below to indicate the reason for the release per this request:

- ☐ Continuing health care needs
- ☐ Disability
- ☐ Transfer of care
- ☐ Care coordination or case management
- ☐ Second opinion/referral
- ☐ Personal
- ☐ Financial assistance
- ☐ Preemployment or medical evaluation
- ☐ Billing, collection or payment of claims
- ☐ Post-employment testing or medical
- ☐ Employment determination (non-work-related illness or injury)
- ☐ Litigations
- ☐ Other, specify _____

I

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 _____

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

J

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 _____

If authorizing release of Marshfield Clinic Health System medical records to an outside organization/person, 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

For any other authorizations, including but not limited to disability/FMLA forms to be sent to insurance companies, employers, etc., send completed authorization to: Health Information Management, HM2, Marshfield Clinic Health System, 1000 North Oak Avenue, Marshfield, WI 54449 Fax: 715-221-5847 E-mail: disability@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.

